Greenfield Pharmacy
Partner in your health care

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1055 Dundas Street West, Mississauga ON, L5C 1C3

Tel: 905-306-1212 Fax: 905-306-1210

Pharmacy Use Only

COVID-19 screening has been conducted and the Patient does not present symptoms of COVID-19 or present with risk of exposure to COVID-19 ☐ Yes ☐ No

MEDICATION/VACCINE ADMINISTRATION SCREENING AND CONSENT FORM

Please complete this form and read the supplemental information provided by the Pharmacist before receiving (name of medication(s)/vaccine(s)). Your answers to these questions will help the Pharmacist determine if the medications/vaccine(s) is/are appropriate at this time. If you are a parent or guardian providing consent for a child or other person, please complete this information for the person who will be receiving the medication(s)/vaccination(s).

PATIENT INFORMATION

Legal First & Last Name:

Age:

Date of Birth ______ / ______ / ______
YYYY MM DD

(collected for clinical assessment & reimbursement)
Sex: ☐ Male ☐ Female ☐ Other

Address:
Street Apartment City Province Postal Code

Health Card #:
(Personal Health Identification Number) – for Manitoba

Telephone:

Emergency Contact Name:
and Phone Number:

Please answer the following questions	Yes	No
Are you **sick today**? (fever greater than 39.5ºC, breathing problems, or active infection)	☐	☐
Do you have an **allergy** to food, medication, vaccine, or latex?	☐	☐
Do you take a **blood thinner** or have a **bleeding disorder**?	☐	☐
Have you had a **serious reaction** to a medication or a vaccine in the past?	☐	☐
Do you have a **new or changing** condition affecting the brain or nervous system?	☐	☐
Have you ever had **Guillain-Barré** syndrome?	☐	☐
For Live Vaccines Only:		
Are you **pregnant, planning to become pregnant** or **breast feeding**?	☐	☐
Do you have a **long-term medical condition** such as asthma, diabetes, lung disease, heart disease or kidney disease?	☐	☐
Do you have a medical condition or are taking medication that **affects your immune system**? (e.g. cancer, HIV, taking prednisone or other corticosteroids long-term)	☐	☐
Have you received any vaccines in the past 4 weeks?	☐	☐
Are you under 18 years of age and taking medication **containing ASA**?	☐	☐

Patient/Agent Consent for Medication/Vaccine Administration

I consent to having the Health Care Professional (HCP) administer (Name of Medication/Vaccine #1, Dose, Route) ________________________ and (if applicable; Name of Medication/Vaccine #2, Dose, Route) ________________________ to the individual named above. I have read and understood the fact sheet(s) regarding the vaccine(s) to be administered. I have had the opportunity to ask questions about the vaccine(s) which were answered to my satisfaction. I understand the risks, benefits, expected outcome and possible side effects of this/these medication(s) and agree to wait in the pharmacy for ___ minutes after receiving the medication(s)/vaccination(s). I agree to see a doctor if I develop any side effects or health problems after receiving the medication(s)/vaccination(s). I agree that the Pharmacy may share my personal health information regarding this/these medication(s)/vaccination(s) as required with public health officials and other healthcare providers.

☐ **I am providing consent for myself**

☐ **I am providing consent for the patient identified above**

If providing consent for patient identified above, complete below:

Contact information of patient agent (name and telephone): ____________________________________

Relationship to person receiving this/these medication(s)/vaccination(s):

☐ Parent ☐ Guardian ☐ Other, please specify ____________________________

Name of person providing consent:

____

Signature of person providing consent:

Date Signed (DD/MM/YYYY): / /

Pharmacy Use Only – Product Not Stored by the Pharmacy

☐ Product is not past the expiry date and is appropriately labelled including:

☐ **Schedule I Products:** Dispensing pharmacy information, patient's name, drug name, strength, DIN, date dispensed and prescribed by a Canadian authorized prescriber.

☐ **Schedule II Products:** Drug name, strength and DIN

☐ **Multidose Vials:** First use or puncture date

☐ Pharmacist has reviewed the following applicable storage conditions and Patient confirms that manufacturer recommended conditions have been maintained.

☐ Refrigeration (2 to 8ºC) OR ☐ Room Temperature (15 to 30ºC)

☐ No exposure to excess light, heat or freezing

ADMINISTERING PHARMACIST	PATIENT/AGENT
Name: ____________________	Name: ____________________
Signature: ____________________	Signature: ____________________
Date: ____________________	Date: ____________________

Pharmacy Use Only – MEDICATION/VACCINE

Medication/vaccine product: Manufacturer: DIN:	Date of administration (yyyy/mm/dd): _____ / _____ / _____ Time of administration: __________ AM/PM
Lot number:	Route and site of administration: ☐ IM ☐ SC
Expiry Date (yyyy/mm/dd): _____ / _____ / _____	Deltoid: ☐ Right ☐ Left ☐ Other: __________
Medication/Vaccine # of total doses required:	Dose: ☐ First Dose ☐ Second Dose ☐ Third Dose
Rationale for medication/vaccine administered:	☐ Prevention of disease; specify ____________________ ☐ Demonstration; specify (ON Only): ____________________ ☐ Other Comments: ____________________
Patient Counseling:	☐ Potential adverse reactions and their management ☐ Other comments: ____________________
Patient response: Adverse reaction: ☐ Yes ☐ No	If yes, describe nature of the reaction and action(s) taken after 15 minutes? ____________________
Follow-up	☐ Yes ☐ No. *(If yes, describe the reason follow-up and timing)* ____________________
Communication ☐ Provincial Immunization Record ☐ Public Health ☐ Healthcare Provider Name: ____________________	Method of notification: ☐ Fax ☐ Phone ☐ Electronic Date notified (yyyy/mm/dd) _____ / _____ / _____ Details: ____________________

I confirm that the patient named in this document is capable of, and has provided consent to, receive the medication(s)/vaccine(s) indicated in this document, or that a parent/guardian or other agent has provided consent on behalf of the patient. I confirm that this/these medication(s)/vaccine(s) should be given to the patient based on assessment. I confirm that the patient/agent has provided informed consent.

Name and Designation of Health Care Professional (HCP) administering vaccine: ____________________

HCP License Number: ____________________ HCP Signature: ____________________

Patient Medication/Vaccine Administration Record

AFFIX LABEL OF ADMINISTERED DRUG

MEDICATION/VACCINE #1

If applicable, next does due date: ____________________

Time of administration: __________ AM/PM

Dose administered: __________

Route of administration: ☐ IM ☐ ________

State of administration: Deltoid: ☐ Right ☐ Left ☐ Other ________

Lot # ________ Expiry: ________

Keep this record in a safe place with your other personal medical information.

Green Field Pharmacy

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Mississauaga, ON, L5C 1C3
Tel : 905 306 1212

Patient Medication/Vaccine Administration Record

AFFIX LABEL OF ADMINISTERED DRUG

MEDICATION/VACCINE #1

If applicable, next does due date:

____

Time of administration: _____________ AM/PM

Dose administered: ____________

Route of administration: ☐ IM ☐ ________

State of administration: Deltoid: ☐ Right ☐ Left

☐ Other ________

Lot # ________ Expiry: ________

Keep this record in a safe place with your other personal medical information.