# PharmaChoice Patient Injection Consent & Administration Record

| Patient information | | |
|---|---|---|
| **Patient Name:**<br>**Patient Age:** | **Postal code** | **Date:** |
| **Cell Phone:** | **Provincial health care number**<br>**Is your card expired?** | |

| **Medical History:** Please complete on the day of your injection | | |
|---|---|---|
| | **Yes/No** | **If yes, please describe** |
| **Have you been outside of the Atlantic Provinces in the past 14 days?** | | **If yes, we are not able to vaccinate you today. Call us at 658-2212.** |
| **Have you been in close contact with anyone who has been outside of the Atlantic Provinces in the past 14 days?** | | **If yes, we are not able to vaccinate you today. Call us at 658-2212.** |
| **Have you had any fever, respiratory symptoms, or other symptoms of Covid 19 in the past 14 days?** | | **If yes, we are not able to vaccinate you today. Call us at 658-2212.** |
| **Are you sick today?** | | |
| **Have you received the flu shot before?** | | |
| **Have you received any vaccination in the last 6 weeks?** | | |
| **Have you ever had a serious reaction or fainted following an injection?** | | |

**Consent:**

- ☐ **I am required to wear a mask inside of the pharmacy at all times.**
- ☐ **I will use the provided hand sanitizer before entering the pharmacy.**
- ☐ **I understand that on the date indicated above, the pharmacist will be administering flu vaccine**
- ☐ **I understand that the pharmacist has been trained and is registered to administer injections by the Prince Edward Island College of Pharmacists.**
- ☐ **Understand that, if required by provincial regulations, my primary health care provider and/or the Chief Public Health Office will be notified that I have received this injection.**
- ☐ **I understand and agree to remain at this location for 15 minutes after the injection as directed by the pharmacist.**
- ☐ **The pharmacist has provided me with information pertaining to the drug being administered as well as the injection procedure so that I understand the expected outcome/reaction as well as the possible side effects. I understand that I may ask the pharmacist further questions at any time before, during, or after the injection.**
- ☐ **In the event of an emergency, I authorize the pharmacist to administer diphenhydramine, epinephrine and/or apply necessary lifesaving procedures as an interim measure until medical support personnel arrive. In case of emergency please contact:**
- ☐ **I have read and understand the above information.**

| **Print Patient name:** | **Signature** |
|---|---|
| | |

| **Pharmacist Use:** | | |
|---|---|---|
| **Drug/Vaccine Administered:** **Fluzone 02420643** | **Lot:** | **Exp Date:** |
| **Fluzone HD 02445646** | **Lot:** | |
| **Administration information** | | |
| **Dose administered: 0.5ml** | **Route: IM** | **Time Administered:** |
| **Dose sequence:** | **Administration site: Deltoid** **right** **left** | |
| **Pharmacist Signature:** | | **Registration Number:** |