Fax

TO:

FROM:

FAX:
PHONE:
SUBJECT: Vaccine Administration Notification

FAX:
PHONE:
DATE

Dear Prescriber,

This notification is to inform you that our mutual patient list on the next page has received the following vaccination(s) at our pharmacy and to facilitate your maintenance of a complete patient record. There is no need to reply to this notification unless you have any questions or concerns.

Thank you,

_____

Pharmacist

Vaccine Consent Form:

Date (MM/DD/YYYY):

Last Name: First Name: Prov. Health Number: Gender: Age: Child's weight: (kg / lb)

Main Phone Number: Alternate Phone Number: Date of Birth (MM/DD/YYYY): Address: City: Province: Postal Code:

Emergency Contact's Last Name: Emergency Contact's First Name: Relationship: Contact's Main Phone Number: Contact's Alternate Phone Number:

Yes No Unsure

Are you/your child currently sick today or have been **sick in the past 3 days**? (fever > 39.5°C, difficulty or change in breathing, active infection)

Have you had difficulty breathing, wheezing or chest tightness within 24 hours of getting a vaccine?

Do you/your child have any **allergies** to medications, food, a vaccine component or latex?

Do you/your child have any immediate or upcoming surgeries?

Do you/your child have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?

Do you/your child have bleeding problems or take blood thinners? (e.g. warfarin)

Have you/your child ever had a seizure or a brain/nervous system problem?

Are you/your child currently pregnant, breastfeeding or plan to be pregnant?

Have you received any other vaccines within the past 4 weeks? If yes, please list:

For live vaccines: In the past 3 months, have you/your child taken any medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?

For live vaccines: Have you/your child ever had a reaction to egg or egg products but can still eat small amounts of egg? (e.g. stomach ache, skin reaction)

I, the undersigned client, parent or guardian, have read or had explained to me information about the vaccine. I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the vaccine. I agree to wait in the clinic/pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the vaccine.

I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called "anaphylaxis" can be life-threatening and are medical emergencies. If I experience such a reaction following vaccination, I am aware that it may require administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try and treat this reaction and that 9-1-1 will be called to provide additional assistance. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat and/or lips.

In the event of anaphylaxis, I will receive a copy of this form containing information on emergency treatments that I had received, or a copy will be provided to my agent or EMS paramedics.

☐I consent that information collected on this form may be shared with my Primary Care Provider and provincial public health unit.

☐I confirm that I/my child want to receive the following vaccine(s): **(Pharmacy to list the vaccines)** _____

_____

_____ _____

Patient/Agent Signature _____

_____ _____

Patient/Agent Name (& Relationship) Date Signed (MM/DD/YYYY)

HEALTH CARE PROVIDER'S DECLARATION:

☐ I confirm the above-named patient is capable of providing consent for the vaccine and that the vaccine should be given to the patient. I am administering the vaccine no more than 21 days after the consent was signed by the Guardian or Committee, Representative, or Temporary Substitute Decision Maker of the patient.

Vaccine:	Arm Administration Site:	Vaccine Lot #:	Vaccine Expiry:
1)		☐Left ☐ Right	
2)		☐Left ☐ Right	
3)		☐Left ☐ Right	
4)		☐Left ☐ Right	

Date of Immunization (MM/DD/YYYY):

Time of Immunization:

Contacted Primary Prescriber: ☐Yes ☐ No

Health Care Provider's Name & License #:

Signature:

NS Only
Patient condition before:
Response during:
Response immediately after:

Emergency Treatment (if provided): ☐ EpiPen® ☐ EpiPen® Junior

# of Doses Administered:

Lot #:

Expiry

_____
Time of Administration:

Epinephrine Emergency Treatment