

# CONSENT FOR IMMUNIZATION WITH FLUMIST® (WRITTEN)

## 1 CLIENT INFORMATION Complete Sections 1, 2, and 3 (please print)

Last Name:		First Name:		Date of Birth (YYYY/MM/DD):	
Address:			Telephone Number:		
Emergency Contact and Relation:			Emergency Telephone Number:		
Personal Health Number:		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender		Pregnancy Status*: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	

## 2 OTHER HEALTH INFORMATION\*

Do you have any of the following:	Yes	No
History of anaphylactic reaction to a previous dose of any type of influenza vaccine or to any component of FluMist®?		
Severe asthma or active wheezing (on high dose inhaled or oral steroids or medically attended wheezing in the 7 days prior to vaccination)?		
Immunocompromising conditions ( <i>applies to both adults and children</i> )?		
History of Guillain-Barré syndrome (GBS) within 8 weeks of receipt of a previous dose of influenza vaccine without another cause being identified?		
For individuals aged 2-17 years: are you currently receiving aspirin-containing therapy?		
Have you received a CTLA-4 inhibitor (eg. ipilimumab) alone or in combination with other checkpoint inhibitors for the treatment of cancer?		
Are you a healthcare worker who work with immunocompromised individuals?		

\*PHARMACIST: If patient answers "Yes" to any of these questions, FluMist® is contraindicated and should not be administered.

## 3 CONSENT Client Parent Legal guardian Representative

I understand the information in the HealthLinkBC File(s) for the vaccine listed below. I understand the benefits and possible reactions of the vaccine and the risk of not getting immunized. I have been informed of any medical reason why the vaccine listed below should not be given to me/my child. I have had the opportunity to ask questions that were answered to my satisfaction. I understand this consent is valid for the vaccine listed below unless the consent is cancelled.

- I consent to receiving/for my child to receive, the vaccine listed below.
- I will stay in the pharmacy for at least 15 minutes after the injection and seek medical attention if needed.
- I will report any adverse effects I experience to the immunizing pharmacist.
- I consent for the information collected on this form to be provided to my Family Physician (or Physician of my choice) and to the Health Authority for entry into my immunization record. I understand the information will be used and disclosed in accordance with the *Freedom of Information and Protection of Privacy Act* and that summary statistical information may be reported to the Ministry of Health.

Name (PRINT) \_\_\_\_\_ Phone \_\_\_\_\_

Signature \_\_\_\_\_ Date signed (YYYY/MM/DD) \_\_\_\_\_

### FOR PHARMACIST USE ONLY

<h4>4 VACCINE INFORMATION</h4> <p>Name of vaccine: _____ DIN: _____</p> <p>Dose: _____ mL Site: LA / RA Route: IM / SC / ID / IN</p> <p>Lot #: _____</p> <p>Expiry date (YYYY/MM/DD): _____</p> <p><small>LA left arm; RA right arm; IM intramuscular; SC subcutaneous; ID intradermal; IN intranasal.</small></p>	Pharmacy Label
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#### 5 PHARMACY INFORMATION

Pharmacist signature: \_\_\_\_\_ Licence number: \_\_\_\_\_

Date of administration (YYYY/MM/DD): \_\_\_\_\_ Time of administration: \_\_\_\_\_

#### 6 CLIENT RESPONSE

Before: Normal Yes  No  \_\_\_\_\_ 15-30 mins post-administration: Normal Yes  No  \_\_\_\_\_

During: Normal Yes  No  \_\_\_\_\_ Other comments: \_\_\_\_\_