Consent for the administration of vaccines/medications

First and Last Name: _____ Birth Date (DD-MM-YY): _____ Age: _____

Address: _____ Telephone: _____

Doctor's name and telephone: _____

Provincial Health Care Number: _____ Weight (if a minor): _____

Emergency contact (name): _____ Telephone: _____

Vaccine/Medication Requested: _____

Your health and safety is a priority. The following questions enable us to evaluate whether there is a medical reason why we cannot provide this service to you. Please let us know if you have any concerns or questions.

Please answer the questions below:

Allergies:

- Have you ever had a serious reaction to any medication or vaccination in the past? Yes ☐ No ☐
  - o If yes, describe: _____
- Are you allergic to the following:
  - o Thimerosal, formaldehyde or any other preservative? Yes ☐ No ☐
  - o Latex? Yes ☐ No ☐
- Are you allergic to antibiotics (including; Neomycin, Kanamycin, Gentamycin, Streptomycin)? Yes ☐ No ☐
  - o If yes, list: _____
- Do you have any food allergies, including to eggs or egg products? Yes ☐ No ☐
  - o If yes, list: _____
- List any other known allergies: _____

Illness:

- Do you presently have a fever, infection, or any acute illness? Yes ☐ No ☐
- Do you have any of the following:
  - o An active or unstable disorder of brain or nervous system (e.g., seizures)? Yes ☐ No ☐
  - o An autoimmune condition/impaired immune system? Yes ☐ No ☐
  - o A bleeding disorder? Yes ☐ No ☐
  - o Asthma? Yes ☐ No ☐
  - o Have you had Guillain-Barre? Yes ☐ No ☐
- List any current medical conditions: _____

Medication:

- Do you take any of the following medications:
  - o Immunosuppressant such as prednisone, other steroids, or anticancer drugs? Yes ☐ No ☐
  - o Blood thinners such as warfarin or ASA? Yes ☐ No ☐
  - o Drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis? Yes ☐ No ☐
  - o Beta-blocker? Yes ☐ No ☐
- Have you received any blood products, immune (gamma) globulin, vaccines, or antiviral drug in the past 30 days? Yes ☐ No ☐
- Do you require a TB skin test within the next 4 weeks? Yes ☐ No ☐
- Do you have a history of a positive TB skin test? Yes ☐ No ☐
- List any medication that you currently take: _____

Pregnancy/Breastfeeding:

- If you are a woman, are you pregnant or think you may be? Yes ☐ No ☐
- If you are a woman, are you planning to become pregnant in the next one month? Yes ☐ No ☐
- If you are a woman, are you currently breastfeeding? Yes ☐ No ☐

Other:

- Are you a resident of Canada? Yes ☐ No ☐
- If you are older than 50 years of age, have you had the shingles vaccine? Yes ☐ No ☐
- Have you ever fainted after receiving an injection? Yes ☐ No ☐
- List any other problems: _____

NOTE: Provincial or College of Pharmacy restrictions may apply. *Rev November 2017*

LONDON DRUGS pharmacy

TRUSTED SINCE 1945

Consent for the administration of vaccines/medications

Initial: _____ I consent to blood testing for blood-borne infections such as Hepatitis B, Hepatitis C and HIV in the event that a health care worker or another individual is exposed to my blood or bodily fluids.

Initial: _____ I consent to the disclosure of my test results for blood-borne infections such as Hepatitis B, Hepatitis C and HIV to a health care provider for the purpose of providing care to an individual who has been exposed to my blood or bodily fluids.

Initial (only if applicable): _____ I supplied the vaccine/medication to the Injection Pharmacist. I am solely responsible for the manner in which the vaccine/medication was stored and handled before providing it to the Injection Pharmacist. I understand that if the vaccine/medication was not properly stored or handled, its stability and effectiveness may be negatively affected for which the Injection Pharmacist and London Drugs bear no responsibility.

POSSIBLE COMMON SIDE EFFECTS/ADVERSE REACTIONS: I understand the explanation provided to me by the pharmacist regarding any possible common side effects or adverse reactions.

Any prolonged or unusual reaction needs to be reported to a doctor. Allergic/anaphylactic responses are rare and are likely a consequence of hypersensitivity to some component of the medication. This reaction is characterized by hives, swelling of the tongue and lips, and/or difficulty breathing. **This is an emergency and requires *immediate* treatment.**

WAIVER: By signing this Consent form, I waive any claim, demand, action or proceeding for any liability, expense, loss or damage of any nature that I (or anyone claiming on my behalf) may have against London Drugs, its directors, officers and employees as well as the administering nurse or pharmacist and medical advisor (collectively the "Releasees") due to any side effect and any personal injury, illness, or death that I experience or suffer directly or indirectly as a result of receiving this vaccine/medication.

Without limiting the intent and effect of the above waiver, I irrevocably submit to the exclusive jurisdiction of the courts of the province in which this injection was administered if I initiate against the Releasees any claim, demand, action or proceeding relating to this injection or this document (collectively, "Claims") and agree that the resolution of all Claims will be governed by and construed in accordance with the laws of the province in which this injection was administered and, to the extent applicable, the laws of Canada.

CONSENT: I have read and understand the risks and benefits of receiving this vaccine/medication. I acknowledge that I have had an opportunity to ask questions and that they were answered to my satisfaction prior to receiving the injection.

I consent to the collection, use and disclosure of the personal information included in this form by and to London Drugs and its nurses, pharmacists, pharmacy employees and medical advisors for the purposes of screening, providing health care services and to assess the need for further medical treatment or response and, where appropriate for reasons of health, safety or medical necessity, other health care professionals, including physicians and hospitals. I understand my family doctor and regulatory or regional health authorities may be notified of this injection of vaccine/medication unless I expressly request that this not be done.

I AGREE TO REMAIN IN THE CLINIC AREA OF LONDON DRUGS FOR A MINIMUM OF 15 MINUTES AFTER I RECEIVE THE INJECTION AND TO IMMEDIATELY NOTIFY THE PHARMACIST OF ANY ADVERSE REACTION. **This is so that I may be observed for the rare occurrence of an anaphylactic reaction, which is an emergency and requires *immediate medical treatment*.** I solely bear the risk of all consequences, including personal injury, illness or death, if I refuse or fail to remain in the clinic area for the time required by the Injection Pharmacist.

Having read, understood and agreed with all the terms of this document, I hereby agree to same by signing where indicated below.

SIGNATURE: _____ **DATE:** _____

Print Name: _____

If the individual to be injected is a minor (under age 18 in Alberta, Saskatchewan, or Manitoba, under age 19 in British Columbia):

I, _____, hereby represent and warrant that I am the legal guardian of the minor to be injected and have the authority to enter into this consent on behalf of the minor.

SIGNATURE (of parent or legal guardian): _____ DATE: _____

Print Name: _____ WITNESS: _____

Provincial law and pharmacy age limits and other restrictions may apply to determine eligibility to receive vaccine. The administering pharmacist or nurse may refuse to administer the vaccine to any person in his/her sole discretion.

RECORD OF ADMINISTRATION TO BE COMPLETED BY THE INJECTION PHARMACIST

Date: _____ Time: _____ Injection Site: _____ Right: ☐ Left: ☐

Dose: _____ Route: Subcutaneous: ☐ Intramuscular: ☐ Intradermal: ☐ Intranasal: ☐ Oral: ☐

Vaccination/medication name: _____ DIN: _____ Expiry Date: _____

Lot Number: _____ Comments: _____ Injection fee charged: $ _____

Signature of the Injection Pharmacist providing Injection: _____

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Rev November 2017

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