Influenza Immunization Record **Save-On-Foods #:** **Location** Print Reset Form

Last Name	First Name	Date of Birth (MM-DD-YYYY)	Age (yrs.)	Sex ☐ Male ☐ Female
Personal Health Number	Address		Phone (Home)	
City	Province **ALBERTA**	Postal Code	Phone (Other)	
Emergency Contact – Last Name	First Name		Emergency Contact Phone No	

Please answer the following questions and check an "X" in the appropriate box	Yes	No	N/A
Is this your first flu shot?			
Do you have a respiratory infection, fever, sudden cough, difficulty breathing, other flu-like or COVID-19 symptoms, and/or risk of COVID-19 exposure? If **yes**, do not attend flu clinic refer to myhealth.alberta.ca for COVID-19 self-assessment)			
Have a history of Guillain-Barre Syndrome within 6 weeks of getting a flu shot?			
Have you ever fainted during or after an injection?			
Have you received any vaccinations in the last 4-6 weeks? Which ones?			
Do you have severe allergic reactions to any medications, components of a vaccine (e.g. neomycin, gentamicin, neomycin, formaldehyde, kanamycin, egg or egg products) or latex?			
Are you <5 years of age? (children < 5 years of age will be immunized by public health) **Note**: Children <9 yrs. of age and have never received a dose of influenza vaccine require, 2 doses with a minimum spacing of 4 weeks between doses. ☐ **First Dose** ☐ **Second Dose**			
Are you on any steroids or immunosuppressive, anticancer, antiviral, or any medications that affect the immune system?			
Do you have cancer, leukemia, HIV, or any other immune system problems?			
During the past year, have you received a blood transfusion, or been given medication called immune (gamma) globulin or had radiation therapy?			
Female only: Are you pregnant or breastfeeding, or planning to get pregnant or breastfeed within the next month?			

I understand there may be some soreness, redness, and swelling at the injection site for a few days. Less common reactions include mild fever, chills, malaise, and/or muscle aches (flu-like symptoms) and may typically resolve within 2-3 days. As with any vaccine, hypersensitivity reaction is possible. This is rare, but may include itchiness, hives, and/or swelling. Save-On-Foods Limited Partnership ("SOF") has provided me with information of other risks related to the vaccine. I request and authorize SOF, through its employees and contractors, to administer the vaccine by injection. I have read and understand the risks of the vaccination and I acknowledge that I have had an opportunity to ask questions which were answered to my satisfaction. In return for the vaccination, I agree to release SOF (including its employees, directors, officers, and contractors) from any and all liability, claims, injury, damages, costs, expenses and compensation whatsoever, howsoever arising, from or in any way connected with the vaccination.

I understand and agree to remain at the location for 15 minutes after the injection as directed by the pharmacist. In the event of an emergency, I authorize the pharmacist to administer epinephrine and/or apply necessary life-saving procedures as an interim measure until medical support personnel arrive. I have read and understand the above information.

Participant Name (Please Print) **Participant/Parent/Caregiver Signature** **Date**

FOR OFFICE USE: INFLUENZA VACCINE

☐ **PATIENT PROVIDED INFORMED CONSENT**

Dose: ☐ Annual ☐ 1st dose ☐ 2nd dose*:

***(specific to children < 9 years after receiving first flu vaccination)**

	Priority List by Reason Code:		**PIN**			
	46	Pregnant women	05666646	☐ FluLaval® Tetra (GSK) 0.5mL	Lot # / Exp.	
	02	Greater than or equal to 65 years of age	05666602	☐ Fluzone® (SF) 0.5mL	Lot # / Exp.	
	67	Children 6 months to 59 months of age	N/A	☐ Afluria® Tetra (Seqirus) 0.5mL	Lot # / Exp.	
	68	5 yrs. to 64 yrs. of age with an eligible chronic condition and/or belong to a high-risk population	05666606	☐ Influvac® Tetra (Mylan) 0.5mL	Lot # / Exp.	
	39	Household or close contacts of individuals in the 46, 02, 67, and 68 reason codes & of children < 6 mos. of age	05666604	☐ Fluzone® High Dose (SF) 0.5mL	Lot # / Exp.	
	69	5 yrs. to 64 yrs. (routine) with no individual risk or not a household contact of an individual in a high-risk pop.	05666605	☐ Other:	Lot # / Exp.	

Injection Date:	Injection Time:	**Site: Arm** ☐ Left ☐ Right **Intranasal** ☐

Immunizer's Name (Print) **Signature** **Date**

Pharmacy Copy