

VACCINATION CONSENT FORM 2026-2027

Name:	Phone #:	
Health Card #:	Date of Birth:	
Address:		Age:
Emergency Contact:	Phone #:	

Which vaccine(s) did you want to receive today?

- ☐ Influenza (Flu)
☐ COVID-19

Please answer the following questions:	YES	NO
Are you feeling sick today? (<i>i.e. fever, cold, infection</i>)		
Have you been vaccinated for COVID-19 or tested positive for COVID-19 in the last 3 months?		
Do you have any allergies? (<i>please specify</i>)		
Have you had a severe, life-threatening allergic reaction to a past vaccine?		
Have you had wheezing, chest tightness or difficulty breathing within 24 hours of getting a vaccine?		
Have you had Guillain-Barré Syndrome within 6 weeks of getting a vaccine?		
Do you have a bleeding disorder or use blood thinners? (<i>e.g. warfarin, aspirin</i>)		

Informed Consent

- I agree to remain at the location for 15 minutes or for the duration specified/directed by the Pharmacist.
- I understand that there are possible adverse effects associated with administration of vaccines.
- I understand that I may, at any time before, during or after the injection, ask the Pharmacist further questions.
- In the event of an emergency, I authorize the Pharmacist to administer epinephrine and/or perform any necessary lifesaving procedures until medical support arrives.
- I understand that the Pharmacist will comply with all professional standards for administering injections. I acknowledge that the pharmacist has discussed the risks and benefits of receiving this injection with me and has answered my questions.

Patient Signature (or Guardian): _____ Date: _____

Guardian Name and Relationship, if applicable: _____

Administration (Pharmacy Use Only):

Patient Name:							
Pharmacist's Declaration: I confirm the above named patient/agent is capable of providing consent, and if written consent cannot be obtained, the patient/agent has provided verbal consent for the administration of the vaccine(s) to the patient. Based on my professional judgment, the vaccine(s) should be administered to the patient.							
INFLUENZA VACCINE			COVID-19 VACCINE				
☐ FLUVIRAL TRIVALENT – DIN 02420686 15 mcg/0.5 mL – 5 mL multidose vial (age 2 or older)			☐ MODERNA SPIKEVAX mRNA– DIN 02541270 0.25 mL/25 MCG – 2.5 mL multidose vial (age 2 years to 11 years)				
☐ FLUZONE TRIVALENT – DIN 02365936 15 mcg/0.5 mL – 5 mL multidose vial (age 2 or older)			☐ MODERNA SPIKEVAX mRNA – DIN 02541270 0.5 mL/50 MCG – 2.5 mL multidose vial (age 12 or older)				
☐ FLUZONE TRIVALENT – DIN 02365707 15 mcg/0.5 mL – 0.5 mL prefilled syringe (age 2 or older)			☐ MODERNA SPIKEVAX mRNA – DIN 02557770 0.5 mL/50 MCG – prefilled syringe (age 12 or older)				
☐ FLUCELVAX TRIVALENT – DIN 02553708 15 mcg/0.5 mL – 0.5 mL prefilled syringe (age 2 or older)			☐ PFIZER COMIRNATY mRNA– DIN 02541823 0.3 mL/30 MCG – 1.8 mL multidose vial (age 12 years or older)				
☐ FLUZONE HIGH-DOSE TRIVALENT – DIN 02445646 60 mcg/0.5 mL – 0.5 mL prefilled syringe (age 65 or older)			☐ PFIZER COMIRNATY mRNA – DIN 02552035 0.3 mL/30 MCG – prefilled syringe (age 12 years or older)				
☐ FLUAD TRIVALENT + adjuvant -- DIN 02362384 15 mcg/0.5 mL – 0.5 mL prefilled syringe (age 65 or older)			☐ NUVAXOVID protein subunit – DIN 02558998 0.5 mL/5 MCG – prefilled syringe (age 12 years or older)				
Lot #:		Exp:		Lot #:		Exp:	
Dose: mL	Route: IM	Site of Administration: ☐ Right ☐ Left _____		Dose: mL	Route: IM	Site of Administration: ☐ Right ☐ Left _____	
Date:				Time:			
Pharmacist's Name and OCP #:				Pharmacist's Signature:			
Notes:							

Affix label(s) here