medSask
YOUR MEDICATION INFORMATION SERVICE

PHARMACY ASSOCIATION OF SASKATCHEWAN

Vaccine Screening Tool and Consent Form

Patient information		
Name: (Last, First)	Date of birth (YYYY-MM-DD)	
Address:		
Health Services Number:	Gender: M / F/ O	Weight:
Daytime Phone Number:	Alternate Phone Number:	
Emergency Contact Information Name:	Phone Number:	

Screening: The following questions will help determine if a vaccine is right for you today. A "yes" to any question does not necessarily mean you should not be vaccinated, but your pharmacist should be aware of it and may have some additional questions for you. Do you (or your child / dependent):		
1. Feel sick today?	Yes	No
2. Have allergies to medications, food, a vaccine component, or latex?	Yes	No
3. Have a history of serious reaction after receiving a vaccination?	Yes	No
4. Have any of the following medical conditions: bleeding problems asthma cancer, HIV/AIDS or other immune system disorders	Yes	No
5. Take any of the following medications (currently, recently): blood thinners (aspirin, warfarin, dabigatran, rivaroxaban, apixaban, edoxaban, etc.) drugs used to treat immune system disorders such as prednisone, other steroids, or anticancer drugs drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, other immune system conditions antiviral drugs	Yes	No
6. Require a TB skin test within next 4 weeks? Have a history of a positive TB skin test?	Yes	No
7. Have close contact with anyone with a severely weakened immune system?	Yes	No
8. For women: Are you pregnant or breastfeeding? Is there a chance you could become pregnant during the next month?	Yes	No
9. Are you planning to travel in the next 4 weeks?	Yes	No
10. Have a history of any vaccinations in the past 4 weeks?	Yes	No
11. During the past year, have a history of receiving a transfusion of blood or blood products, or immune (gamma) globulin?	Yes	No

Q1-5 Injectable inactivated influenza vaccine

Q1-10 Other vaccines

Declaration of Consent:

I confirm that I have read or had explained to me the attached vaccine information sheet regarding the risks, benefits and potential side effects associated with the vaccine(s). I have had the opportunity to have my questions answered by the pharmacist and am satisfied with and understand the information I have been given. I consent to pharmacist prescribing and/or administering vaccine(s) for myself or my child / dependent.

____ _____________________

Signature of: ¨ **Vaccine recipient** ¨ **Parent /guardian** **Date**

For Pharmacist Use Only						
Vaccine: Name, DIN, Lot #, Expiry Date	**Dose**	**Site**	**Route**	**Dose #**	**Pharmacist Signature**	**Date &Time of Injection (If applicable)**
1.						
2.						
3.						
4.						
Adverse reaction: ¨ **No** ¨ **Yes – describe reaction below.** ¨ **Completed Adverse Event following Injection (AEFI)** form						
¨ **Notified primary care practitioner (if applicable): Name**___________________________________ **Fax #:**____ ____________________ ¨ **Reported immunization to electronic provincial registry (if applicable)** ¨ **If vaccination series, appointment date for next injection:** ________________________________						

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