# Consent for the administration of vaccines/medications

First and Last Name: ______________________ Age: ______ Birth Date: ______________

Address: ______________________ Telephone: ______________

Doctor's name and telephone: ______________________

PHN (Personal Health Number): ______________________ Weight (if a minor): ______________

**Vaccine/Medication Requested:** ______________________

Note: Injections will not be provided to any children younger than 5 years of age. These individuals will be referred back to their physicians. The parent or legal guardian must be present before an injection will be provided to any child age 5 to 18 years.

Name and relationship of person requesting injection for a minor (5 to 18 years):

______________________

*Your health and safety is a priority. The following questions are to ensure that you do not have any contraindications and so we can provide appropriate counselling. 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 in the past? Yes ☐ No ☐
  - If yes, describe: ______________________
- Are you allergic to the following:
  - Thimerosal, formaldehyde or any other preservative? Yes ☐ No ☐
  - Latex? Yes ☐ No ☐
- Are you allergic to antibiotics (including; Neomycin, Kanamycin, Gentamycin, Streptomycin)? Yes ☐ No ☐
  - If yes, list: ______________________
- Do you have any food allergies, including to eggs or egg products? Yes ☐ No ☐
  - 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:
  - An active or unstable disorder of the nervous system? Yes ☐ No ☐
  - An autoimmune condition? Yes ☐ No ☐
  - A bleeding disorder? Yes ☐ No ☐
  - Have you had Guillain-Barré? Yes ☐ No ☐
- List any current medical conditions: ______________________

**Medication:**

- Do you take any of the following medications:
  - Immunosuppressant such as a Corticosteroid or Prednisone? Yes ☐ No ☐
  - Anticoagulant such as Warfarin or ASA? Yes ☐ No ☐
  - Beta-blocker? Yes ☐ No ☐
- Have you received any blood products or vaccines in the past 30 days? 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 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: ______________________



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**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 (age 5 to 18):**

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: ____________________

**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: ____

Manufacturer: __________________ Brand: __________________ Expiry Date: __________

Lot Number: ____________ Comments: ______________________________________

Signature of the Injection Pharmacist providing Injection: ______________________________



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# Consent for the administration of vaccines/medications

*The following may be completed if more than one vaccine/medication are administered on same day or for a vaccine series within a 6-month period:*

Patient's name: ____________________________________________

**RECORD OF ADMINISTRATION TO BE COMPLETED BY THE INJECTION PHARMACIST**

Date: ____________________ Time: ____________ Injection Site: _______________ Right: ___________ Left: __________

Dose: __________ Route: Subcutaneous: _______ Intramuscular: _______ Intradermal: _______ Intranasal: _______ Oral: _______

Manufacturer: ____________________________ Brand: ____________________________ Expiry Date: _______________

Lot Number: __________________ Comments: ______________________________________________________________

*Confirm with patient no changes to questionnaire answers:* ______________________________________________

Signature of the Injection Pharmacist providing Injection: ________________________________________________

**RECORD OF ADMINISTRATION TO BE COMPLETED BY THE INJECTION PHARMACIST**

Date: ____________________ Time: ____________ Injection Site: _______________ Right: ___________ Left: __________

Dose: __________ Route: Subcutaneous: _______ Intramuscular: _______ Intradermal: _______ Intranasal: _______ Oral: _______

Manufacturer: ____________________________ Brand: ____________________________ Expiry Date: _______________

Lot Number: __________________ Comments: ______________________________________________________________

*Confirm with patient no changes to questionnaire answers:* ______________________________________________

Signature of the Injection Pharmacist providing Injection: ________________________________________________

**RECORD OF ADMINISTRATION TO BE COMPLETED BY THE INJECTION PHARMACIST**

Date: ____________________ Time: ____________ Injection Site: _______________ Right: ___________ Left: __________

Dose: __________ Route: Subcutaneous: _______ Intramuscular: _______ Intradermal: _______ Intranasal: _______ Oral: _______

Manufacturer: ____________________________ Brand: ____________________________ Expiry Date: _______________

Lot Number: __________________ Comments: ______________________________________________________________

*Confirm with patient no changes to questionnaire answers:* ______________________________________________

Signature of the Injection Pharmacist providing Injection: ________________________________________________



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