Vaccination Consent Form

By provincial legislation, Pharmacists cannot administer certain vaccines to children under a certain age. Ask your pharmacist for age restrictions.

Name:		**Provincial Health Number:**
Date of Birth (MM/DD/YYYY):	**Age:**	**Gender:**
Address:		**Patient Phone:**
Emergency Contact Name:	**Contact Phone:**	**Relationship to Patient:**

Injection Screening Questionnaire

	✔Yes	✖No
1. Are you sick today? (fever greater than 39.5°C, breathing problems, or active infection)		
2. Have you had this vaccine or a similar vaccine before? If yes, please specify date of last shot:		
3. Is your immune system affected by a severe disease or medication? If yes, please specify:		
4. Are you pregnant or breastfeeding/nursing?		
5. Do you have any allergies? (Including: medications; vaccines; eggs; latex or natural rubber; and polyethylene glycol or polysorbate) If yes, please specify:		
6. Have you ever had a severe reaction (e.g. Guillain-Barre Syndrome, allergic reaction) or have experienced fainting, wheezing, chest tightness, or difficulty breathing following a vaccine? If yes, please specify:		
7. Have you received any other vaccines in the last 4 weeks? If yes, please specify:		
8. Do you have a bleeding disorder or are you taking blood thinners? If yes, please specify: (eg. Warfarin, Apixaban, Rivaroxaban, Clopidogrel)		

Preferences (Optional)

Preferred injection site:
☐ Left arm ☐ Right arm

Privacy Preference:
Do you wish to receive the injection in a private area (e.g., private room or behind a privacy curtain)?
☐ Yes ☐ No preference

Accompaniment Preference:
Do you wish to have a person accompany you during the injection?
☐ Yes ☐ No preference

Consent

☐ I understand that the pharmacist will be administering the drug and dose listed below. The pharmacist has explained the purpose of this drug, the procedure for administering it, the location on my body where it will be administered, the method of administration, and the expected duration of the procedure.

The pharmacist has discussed the risks, benefits, and possible alternatives to receiving this drug, and has answered all of my questions to my satisfaction. I understand that there are possible adverse effects associated with the administration of the drug.

I agree to remain in the clinic or pharmacy for 15 minutes (or the time recommended by the pharmacist) after receiving the injection and will seek medical attention if needed.

In the event of an emergency, I authorize the pharmacist to administer epinephrine and/or perform lifesaving procedures until medical assistance arrives, and to contact the emergency contact listed above.

I understand that the pharmacist named below is authorized and registered by the province's pharmacy regulatory college to administer injections or drugs by inhalation, and will comply with all applicable professional standards for drug administration.

Name: (Print) _____ **Patient/Agent Signature:** _____

Date signed: (MM/DD/YYYY) _____ ☐ Patient verbal consent provided.

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☐ Other:	☐ Influenza	☐ Influenza (High Dose)	☐ COVID-19	☐ RSV	☐ Pneumococcal	☐ Shingles (Zoster)	☐ Tetanus/ Diphtheria/ Pertussis
			Eligibility Screening - No History Reported:	☐	☐	☐	☐

Vaccine #1: _____ (Print Vaccine Name)

DIN: _____ Lot #: _____ Expiry Date: _____

Dose: _____mL ☐ Left Arm ☐ Right Arm ☐ Other _____

Route: ☐ Intramuscular ☐ Subcutaneous ☐ Intradermal ☐ Intranasal

Diluent: _____ DIN: _____

Qty: _____mL Lot: _____ Expiry: _____

Vaccine #2: _____ (Print Vaccine Name)

DIN: _____ Lot #: _____ Expiry Date: _____

Dose: _____mL ☐ Left Arm ☐ Right Arm ☐ Other _____

Route: ☐ Intramuscular ☐ Subcutaneous ☐ Intradermal ☐ Intranasal

Diluent: _____ DIN: _____

Qty: _____mL Lot: _____ Expiry: _____

Vaccine Administrator Information

Signature: _____ **License number:** _____

Date of administration (YYYY/MM/DD): _____ **Time of administration:** _____

Additional Eligibility Criteria

☐ Chronic/High Risk: _____ (Specify)
☐ Healthcare Provider ☐ Other congregate living
☐ Household High Risk ☐ High Risk Community

Updated July 2, 2026