Faircare Pharmacy
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MEDICATION/VACCINE ADMINISTRATION SCREENING AND CONSENT FORM

Please complete this form and read the supplementary information provided by the Pharmacist before receiving the vaccine.

Patient Information		
First Name:	Last Name:	
Date of Birth (mm/dd/yyyy):	Age:	Gender: ☐ M ☐ F ☐ Other:_____
Address:		
Health Card #:	Telephone:	
Emergency Contact Name	and Telephone Number:	

Screening Questionnaire for Person Receiving Medication/Vaccination	√ Yes	× No
Are you sick today (i.e. fever greater than 39.5° C, breathing problems, active infection)?		
Do you have any allergies to food, or medication, including vaccines; eggs or egg product; latex or natural rubber; and polyethylene glycol or polysorbate? If yes, please specify:_____		
Do you take a blood thinner or have a bleeding disorder?		
Have you had a serious reaction (e.g. Guillain-Barre syndrome allergic reaction) or have experienced fainting, wheezing, chest tightness, or difficulty breathing to a medication or vaccine in the past?		
Do you have a new changing condition affecting the brain or nervous system?		
Have you received any other vaccine in the last four (4) weeks? If yes, please specify:_____		
Have you had this vaccine or similar before? If yes, please specify date of last shot:_____		
Is your immune system affected by a severe disease or medication? If yes, please specify:_____		
Are you pregnant or breastfeeding/nursing?		

Patient/Age Consent for Medication/Vaccine Administration

I consent to having FairCare Pharmacy administer the vaccine and have explained to me the information about this vaccine and procedure provided to me and the pharmacist answered my questions. I understand the risks, benefits, expected outcome and possible side effects of this vaccine and agree to wait in the pharmacy for **15** minutes after receiving the vaccination. I agree to seek medical attention if needed. I agree that FairCare Pharmacy may share my personal health information regarding this vaccination as required with public health officials and other healthcare providers.

Relationship to person receiving the medication/vaccination:

☐ Parent ☐Guardian ☐ Other (please specify) _____

Name _____Signature _____Date: _____ / _____ / _____
mm dd yyyy

☐ Patient Verbal Consent Provided

FOR PHARMACIST USE ONLY

☐ Flu	☐Flu-HD High Dose	☐Covid 19	☐RSV	☐ Zoster (Shingles)	☐ Pneumonia	☐ Other

Vaccine #1:_____	**Vaccine #2:**_____
DIN:_____Lot#:_____Expiry:_____ Dose: ____mL Deltoid: ☐ Right ☐ Left ☐ Other: _____ Route: ☐ IM ☐ SC ☐ Intradermal ☐ Intranasal	DIN:_____Lot#:_____Expiry:_____ Dose: ____mL Deltoid: ☐ Right ☐ Left ☐ Other:_____ Route: ☐ IM ☐ SC ☐ Intradermal ☐ Intranasal
Diluent:_____DIN_____ Qty:_____mL Lot:_____ Expiry_____	Diluent:_____DIN_____ Qty:_____mL Lot:_____ Expiry_____
Pharmacist Information Pharmacist Signature: License #:_____ Date (mm/dd/yyyy): Time_____ AM/PM	Additional Eligibility Criteria ☐ Chronic/High Risk: _____ ☐ Healthcare Provider ☐ Other Congregate Living ☐ Household High Risk ☐ High Risk Community