CONSENT AND RELEASE – GENERAL VACCINATION

Client Last Name	Client First Name	Date of Birth (YYYY / MM / DD)	Gender M F
Provincial Health Number	Emergency Contact – Name and Phone No.		Prescriber
Address	City	Postal Code	Home Phone Number

1. **Risks**: I understand there may be some soreness, redness, and swelling at the injection site for a few days. Less common reactions include mild fever, chills, malaise, and/or muscle aches (flu-like symptoms) and may typically resolve within 2 to 3 days. As with any vaccine, hypersensitivity reaction is possible. This is rare, but may constitute pruritis, urticaria, or angioedema. Overwaitea Food Group LP ("OFG") has provided me with information of other risks related to the vaccine.
2. **Consent**: I request and authorize OFG, through its employees and contractors, to administer the vaccine by injection. I have read and understand the risks of the vaccination and I acknowledge that I have had an opportunity to ask questions which were answered to my satisfaction.
3. **Release**: In return for the vaccination, I agree to release OFG (including its employees, directors, officers, and contractors) from any and all liability, claims, injury, damages, costs, expenses and compensation whatsoever, howsoever arising, from or in any way connected with the vaccination.

Please answer the following questions and check the approximate box

		Yes	No	N/A
Vaccine History	**All patients:** is this your first ever flu shot?			
	All patients: Have you received a **Tetanus vaccine** in the last 10 years?			
	Patients > 50 years or older: Have you ever received the **SHINGLES** vaccine?			
	Patients who have Chronic Lung, Chronic Kidney, or Heart Disease, Diabetes, Smoke, or 65 years of age: Have you received the **PNEUMONIA** vaccine?			
All	Do you have a respiratory infection or other active infection, illness or fever (cold or flu)?			
	Have you had shingles in the past 12 months?			
	Have you ever fainted during or after an injection?			
	Have a history of Guillian-Barre Syndrome within 6 weeks of getting a flu shot?			
	Have you ever had a severe allergic reaction (hives, throat swelling, difficulty breathing, and/or shock) to any medications, injections, egg or egg products, gelatin, bee stings, thimerosal, neomycin, gentamicin, formaldehyde, kanamycin, neomycin, and/or latex?			
	Female only: Are you pregnant or breastfeeding, or planning to get pregnant or breastfeed within the next month?			
	Do you take a blood thinner (i.e. warfarin) or have a bleeding disorder?			
Tdap	Do you have a seizure disorder or brain disorder? (for pertussis containing vaccines)			
Live Vaccines (FluMist, Shingles)	Have you received any vaccinations in the last 4-6 weeks? Which ones?			
	Are you on any steroids or immunosuppressive, anticancer, antiviral, or any medications that affect the immune system?			
	Do you have cancer, leukemia, HIV, active shingles, or any other immune system problems?			
	During the past year, have you received a blood transfusion, or been given medication called immune (gamma) globulin or had radiation therapy?			

Note: **If you have answered "Yes" to any of the above questions, your pharmacist may ask you further questions**. I understand and agree to remain at the location for 15-30 minutes after the injection as directed by the pharmacist. In the event of an emergency, I authorize the pharmacist to administer epinephrine and/or apply necessary life- saving procedures as an interim measure until medical support personnel arrive. I have read and understand the above information.

______________________ ______________________ ______________________
Participant Name Participant Signature Date

______________________ ______________________ ______________________
Name of Immunizer Pharmacist Signature Date

Vaccine Name	Route	Injection site (deltoid muscle)	Manuf.	Lot #	Dose	Exp. Date	Date of Immunization
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