PACIFIC BLUE CROSS®

CONSENT AND RELEASE – PBC FLU VACCINATION

Client Last Name	Client First Name	Date of Birth (YYYY/MM/DD)	Gender ◯ M ◯ F
Provincial Health Number	**Ministry**		
Home Address	**City**	**Postal Code**	**Phone Number**

All of the above fields are required for vaccines to be processed through PharmaNet.

Please bring this form with you to the immunization clinic. Please wear short sleeves.

ALL QUESTIONS MUST BE ANSWERED PRIOR TO IMMUNIZATION.

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 itchiness, hives or swelling. Any prolonged or unusual reaction needs to be reported to a doctor. Please also report these reactions to Pacific Blue Cross at 604-419-2027.
2. **Consent**: I request and authorize Pacific Blue Cross, through its employees and contractors, to administer the vaccine by injection.
3. **Release**: In return for the vaccination, I agree to release Pacific Blue Cross (including its employees, directors, officers, and contractors), including Overwaitea Food Group LP and London Drugs from any and all liability, claims, injury, damages, costs, expenses and compensation whatsoever, howsoever arising, from or in any way connected with the vaccination.
4. Any questions can be directed to Pacific Blue Cross at fluclinics@pac.bluecross.ca or 604-419-2027.

Please answer the following questions and check the appropriate box:	**Yes**	**No**	**N/A**
Is this your first ever flu shot?	◯	◯	◯
Do you have a respiratory infection or other active infection, illness or fever (cold or flu)?	◯	◯	◯
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?	◯	◯	◯
Do you take a blood thinner (i.e. warfarin) or have a bleeding disorder?	◯	◯	◯
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?	◯	◯	◯
Female only: Are you pregnant or breastfeeding, or planning to get pregnant or breastfeed within the next month?	◯	◯	◯

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 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. The registered pharmacist has provided me with information of the risk related to the vaccine and I have had an opportunity to ask questions which were answered to my satisfaction. I have read and understand the above information.

Participant Name	Participant Signature (Sign with Pharmacist.)	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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Print Form