## 2023-2024 Seasonal Influenza (Flu) +/- COVID Vaccine Consent Form

threatening medical emergencies. Symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. If I experience such symptoms following vaccination, I am aware it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to treat this reaction and 9-1-1 will be called to provide additional assistance. In the event of anaphylaxis, I, my agent, and/or EMS paramedics will	Section 1: Patient Information											
Soction 2: Screening Questionnaire  In the past 10 days have you experienced any of the following: fever, new onset of cough or worsening of chronic cough, new or worsening shortness of breath or difficulty breathing, sore throat, runny nose, feeling unwell?  In the past 10 days have you experienced any of the following: fever, new onset of cough or worsening of chronic cough, new or worsening shortness of breath or difficulty breathing, sore throat, runny nose, feeling unwell?  In the past 10 days have you experienced any of the following: fever, new onset of cough or worsening of chronic cough, new or worsening shortness of breath or difficulty breathing?  In the past 10 days have you experienced any in the following: fever, new onset of cough or worsening of chronic cough, new or worsening shortness of breath or difficulty breathing?  In you have allergies to medications, food (e.g., e.g., e.g., yacking components or late?)  Do you have an interest of cough in the state of the past of a past of the past of t	Last Name:		First Name:			Prov. Health Number:			Gender:		Age:	
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O.5mL IM pre-filled syringe DIN 02473283 O.5mL IM 5mL multi-dose vial DIN 02434881  O.5mL IM 5mL multi-dose vial DIN 02434881  O.5mL IM 5mL multi-dose vial DIN 02430686  FLUZONE® QUAD O.5mL IM single-dose vial DIN 02420643 O.5mL IM 5mL multi-dose vial DIN 02420783  FLUCELVAX® QUAD O.5mL IM pre-filled syringe DIN 02420643 O.5mL IM pre-filled syringe DIN 02420643 O.5mL IM pre-filled syringe DIN 02420643 DIN 02420783  Flu Vaccine  Lot #:  Expiry Date (MM/YYYY): Site of Administration: Left Arm Right Arm  Health Care Provider's Name and License Number:  OTHER O.5mL IM DIN 02420686  O.5mL IM DIN 02420686  FluMIST QUAD O.1mL per nostril DIN 02426544  DIN 02426544  Time of Immunization: (MM/DD/YYYY): Left Arm Right Arm  Health Care Provider's Signature:	AFLURIA TETF	₹A	□ FLUAD Pe	ediatric <sup>®</sup>	□ FLU	AD®	□ FLUZONE <sup>®</sup>		□ FLUVIRAL <sup>®</sup>		□ COVID/	
DIN 02473233  0.5mL IM 5mL multi-dose vial DIN 02473313  FLUZONE® QUAD  0.5mL IM single-dose vial DIN 02420643  0.5mL IM 5mL multi-dose vial DIN 02420783  DIN 02420643  0.5mL IM 5mL multi-dose vial DIN 02420783  Flu Vaccine  Lot #: Expiry Date (MM/YYYY): Site of Administration: Left Arm Right Arm Intranasal  Flu Vaccine #2  Lot #: Expiry Date (MM/YYYY): Site of Administration: Left Arm Right Arm  Health Care Provider's Name and License Number:  Health Care Provider's Signature:			0.25mL IM		0.5mL IM		High-Dose		0.5mL IM	,	OTHER	
□ 0.5mL IM single-dose vial DIN 02420643 □ 0.5mL IM pre-filled syringe DIN 02494248 □ 0.5mL IM DIN 02484854 □ 0.5mL IM DIN 02420783 □ 0.5mL IM DIN 02432730 □ Lot #: Expiry Date (MM/YYYY): Site of Administration: Left Arm □ Intranasal □ Time of Immunization: Left Arm □ Right Arm □ Intranasal □ Improvact TETRA 0.5mL IM DIN 02484854 □ D	□ 0.5mL IM 5mL multi-dose vial		DIIV 02404001		DIN 02302304		0.7mL IM		DIN 02420000			
□ 0.5mL IM single-dose vial DIN 02420643 □ 0.5mL IM pre-filled syringe DIN 02494248 □ 0.5mL IM DIN 02484854 □ 0.5mL IM DIN 02420783 □ 0.5mL IM DIN 02432730 □ Lot #: Expiry Date (MM/YYYY): Site of Administration: Left Arm □ Intranasal □ Time of Immunization: Left Arm □ Right Arm □ Intranasal □ Improvact TETRA 0.5mL IM DIN 02484854 □ D	FLUZONE <sup>®</sup> QUA	D			FLUCE	I VAX <sup>®</sup> QUAD			_			
DIN 02494248 DIN 02426544 DIN 02484854  Flu Vaccine Lot #: Expiry Date (MM/YYYY): Site of Administration: Left Arm   Right Arm   Intranasal  Vaccine #2 Lot #: Expiry Date (MM/YYYY): Site of Administration: Left Arm   Right Arm   Intranasal  Health Care Provider's Name and License Number: Time of Immunization: MM/DD/YYYY): Health Care Provider's Signature:	☐ 0.5mL IM single-dose vial		_					QUAD	_	D	ose:	
Flu Vaccine  Lot #: Expiry Date (MM/YYYY): Site of Administration: Left Arm □ Right Arm □ Intranasal  Time of Immunization: (MM/DD/YYYY):  Vaccine #2  Lot #: Expiry Date (MM/YYYY): Site of Administration: Left Arm □ Right Arm  Time of Immunization: (MM/DD/YYYY):  Health Care Provider's Name and License Number:  Health Care Provider's Signature:	☐ 0.5mL IM 5mL multi-dose vial		DIN 02420783		, ,		nostril					
Health Care Provider's Name and License Number:  Health Care Provider's Signature:			. , , ,									
Health Care Provider's Name and License Number:  Health Care Provider's Signature:	Vaccine #2	Lot #:	Expiry Date (WiW/ 1 1 1 ).						Time of Immuniza	tion:		
NS Only Patient condition before: Response during: Response immediately after:									Health Care Provider's Signature:			
	NS Only	Only Patient condition before:					Response during:			Response immediately after:		