NEWE TOWNE MEDICAL PHARMACY

COVID & FLU VACCINES - SCREENING AND CONSENT FORM – 2025-2026

Section 1: Patient Information

*First Name (as on OHIP)	*Last Name (as on OHIP)	*Health Card No.:	☐ Male ☐ Female ☐ Prefer not to answer

*Date of Birth (MM/DD/YYYY):	Age:	Tel:	Email:

Name of Emergency Contact AND Relationship:	Emergency Contact's Phone Number:

Section 2: Screening Questionnaire

	Yes	No
Have you been sick in the past few days? Do you have symptoms of COVID-19 or have a fever in the last 24 hours (e.g., chills, cough, shortness of breath, tiredness, sore throat, runny or stuffy nose, etc.)?		
Have you had a serious allergic reaction to a vaccine or medication given by injection (e.g. IV, IM) needing medical care?		
Have you ever felt faint or fainted after receiving a vaccine or medical procedure?		
Are you allergic to any medications including vaccines?		
Do you have any serious allergy to latex or natural rubber?		
Do you have bleeding problems or use blood thinners (e.g. warfarin, ASA, rivaroxaban, etc.)?		
Have you received any other vaccines within the past 4 weeks? If so, which one(s)?		
Section 2a: Complete this section if receiving Flu Vaccine	**Yes**	**No**
Are you allergic to any part of the flu shot, or have you had a severe, life-threatening allergic reaction to a past flu shot? (Note: egg allergies without other contraindications may be vaccinated as per NACI guidelines)		
Have you had wheezing, chest tightness or difficulty breathing within 24 hours of getting a flu shot?		
Have you had Guillian-Barré Syndrome within 6 weeks of getting a flu shot?		
Do you have any new or changing neurological disorder?		
Section 2b: Complete this section if receiving COVID Vaccine	**Yes**	**No**
Have you been diagnosed with myocarditis or pericarditis following a previous dose of an mRNA COVID-19 vaccine (e.g. Comirnaty® (Pfizer BioNTech), Spikevax® (Moderna))?		
Have you had a serious allergic reaction within 4 hours of a COVID vaccine in the past?		
Have you had a known, or suspected allergy, or a severe anaphylactic allergic reaction (e.g. difficulties breathing, itchy/swelling of mouth or throat, hives) to polyethylene glycol [PEG], polysorbate 80 or tromethamine?		
Do you have a weakened immune system or are you taking any medications that can weaken your immune system (e.g. high dose steroids, chemotherapy)? *If yes, are you receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies, or other targeted agents?*		
Has it been a **minimum** of 84 days since your last COVID-19 vaccine dose?		

Section 3: Vaccine Administration Consent

- I have had an opportunity to ask questions about the diseases and the vaccines, and to have them answered to my satisfaction.
- I understand that I may withdraw this consent at any time for myself or for an individual for whom I am a substitute decision maker.
- I consent to have the Health Care Professional (HCP) administer the flu and/or COVID-19 vaccine to the individual named above.
- I understand the risks, benefits, expected outcome and possible side effects of this vaccine and agree to wait in the pharmacy for 15 minutes (or time recommended by the pharmacist) after receiving the vaccination(s).
- **I agree that the pharmacy may share my personal health information regarding this vaccination as required with public health officials and other healthcare providers, including on COVaxON.**

☐ **I am providing consent for myself** **OR** ☐ **I am providing consent for the patient identified above**	☐ I consent to the COVID vaccine being given to myself or to the person for whom I am authorized to give consent. ☐ I consent to the influenza vaccine for 2025-2026 being given to myself or to the person for whom I am authorized to give consent.

Patient/Agent Name (& Relationship to person receiving this vaccination):	**Patient/Agent Signature:**	**Date (MM/DD/YYYY):** MM / DD / 2026

PHARMACIST DECLARATION: I confirm that the patient named in this documentation is capable of, and has provided consent to, receive this COVID-19 vaccine and/or flu vaccine indicated in this document, or that a parent/ guardian or other agent has provided consent on behalf of the patient. I confirm that this COVID-19 and/or flu vaccine should be given to the patient based on my assessment. I confirm that the patient/agent has provided informed consent.

Pharmacist Signature:	**OCP License (See Below)**	**Date (MM/DD/YYYY):** MM / DD / 2026

Section 4: Pharmacy Use Only

COVID Vaccine		**Flu Vaccine**	
SPIKEVAX® Vaccine (Moderna) ☐ MDV DIN 0254**1270** ☐ PFS DIN 0255**7770**	COMIRNATY® Vaccine (Pfizer-BioNTech) ☐ MDV DIN 0254**1823** ☐ PFS DIN 0255**2035**	☐ AFLURIA **(MDV)** DIN 0247**3283** Eligibility: Age 6 months + ☐ FLUCELVAX ® QUAD **(PFS)** DIN 0249**4248** ****USE IF EGG ALLERGY**** Eligibility: Age 6 months+ ☐ FLULAVAL TETRA® **(MDV)** DIN 0242**0783** Eligibility: Age 6 months+ ☐ FLUZONE HIGH-DOSE® DIN 0244**5646** Eligibility: Age 65yo+ (senior)	☐ FLUZONE QUAD® **(MDV)** DIN 0243**2730** Eligibility: Age 6 months+ ☐ FLUZONE QUAD® **(PFS)** DIN 0242**0643** Eligibility: Age 6 months + ☐ FLUVIRAL ® **(MDV)** DIN 0242**0686** Eligibility: Age 6 months+ ☐ FLUAD Adj-TIV® DIN 0236**2384** Eligibility: Age 65yo+ (senior)
Dose: ***0.5mL***	Dose: **0.3mL**	Dose: 0.5mL (0.7mL for Fluzone HD)	
Route: IM	Route: IM	Route: IM	
Vaccine Lot#:	Vaccine Lot#:	Vaccine Lot#:	Vaccine Expiry:
Vaccine Expiry:	Vaccine Expiry:		
Site of Administration: ☐ **Left Deltoid** ☐ **Right Deltoid**		**Site of Administration:** ☐ **Left Deltoid** ☐ **Right Deltoid**	
Date of Immunization: MM / DD / 2026		**Date of Immunization:** MM / DD / 2026	
Time of Immunization: ____:____ **AM/PM**		**Time of Immunization:** ____:____ **AM/PM**	

Administering Pharmacist Name and OCP#:

◯ Andrew John Samuel (624627) ◯ Josee Joseph (617880) ◯ ____ (OTHER)

Administering Pharmacist Signature:

Adverse Event Following Immunization? ☐ **Yes** ☐ **No**

If yes, describe nature of reaction and action(s) taken after 15 minutes?