Full Name	
Date of Birth	
Health Card #	
Address	
Phone Number	

Influenza Virus:

Influenza is a respiratory illness caused primarily by the influenza A and B viruses. While most people recover within a week to 10 days, severe illness can occur. Some people are at a greater risk of influenza-related complications.

COVID-19

Coronaviruses are a large family of viruses that usually cause mild to moderate upper-respiratory tract illnesses in humans. COVID-19 is a novel coronavirus that was not typically found in humans that caused severe illness and death in some cases. Those at higher risk for complications include older adults and those with chronic health issues or respiratory problems.

Respiratory Syncytial Virus:

Respiratory syncytial virus (RSV) infection is a major cause of lower respiratory tract illness, particularly among infants, young children and older adults. In Canada, RSV causes yearly outbreaks of respiratory tract disease, usually starting in late fall and running through to early spring. Reinfections with RSV are common but illness is usually milder with subsequent infections until older adulthood, when RSV can again lead to severe disease.

I would like to receive the following vaccines:

- ☐ **Influenza Vaccination**
- ☐ **COVID-19 Vaccination**
- ☐ **Respiratory Syncytial Virus (RSV) Vaccination (65+ only)**

Combined Vaccine Consent Form

Janzen's PHARMACY

Screening Questions:

Are you pregnant?	No	Yes
Are you feeling ill?	No	Yes
Have you been diagnosed with COVID-19 in the last 6 months?	No	Yes
Do you have any allergies you are aware of?	No	Yes
Have you been told by a medical professional in the past not to receive a vaccine?	No	Yes
Are you currently taking medication that compromises your immune system?	No	Yes
Do you have HIV, Hepatitis C or another bloodborne illness?	No	Yes
Have you had an allergic reaction to a vaccine in the past?	No	Yes
Do you have a bleeding disorder?	No	Yes
Have you been diagnosed with a neurological disorder?	No	Yes
Are you taking any blood thinners, including aspirin?	No	Yes
Have you received any vaccines in the last 28 days?	No	Yes

Please explain any "Yes" answers provided above:

I, the undersigned, give my consent and affirm that I wish to receive the vaccinations I have indicated on this form.

I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called "anaphylaxis" can be life-threatening and are deemed medical emergencies. If I experience such a reaction following vaccination, I am aware that it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 911 will be called to provide additional assistance to the immunizer.

The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. In the event of anaphylaxis, I will receive a copy of this form containing information on emergency treatments that I had received, or a copy will be provided to my agent or EMS paramedics.

Signature: _____ Date: _____

Name: _____ Relationship to Patient: _____

Staff Use:				
	COVID-19	Lot:	Exp:	( ) R ( ) L Deltoid
	Influenza	Lot:	Exp:	( ) R ( ) L Deltoid
	RSV	Lot:	Exp:	( ) R ( ) L Deltoid