NIAGARA NORTH
Family Health Team

Influenza (Flu) Vaccine Screening and Consent Form

<table>
<tr><td>Legal Name:</td><td colspan="2">First</td><td colspan="2">Last</td></tr>
<tr><td>Weight (est)</td><td colspan="4">Circle how much you/child approximately weight?
More than 46kg/100lbs Standard Epi-Pen
Less than 30kg/66lbs Junior Epi-Pen</td></tr>
<tr><td>Age:</td><td colspan="4"></td></tr>
<tr><td>Phone Number:</td><td colspan="2">☐ Cell:</td><td colspan="2">☐ Home:</td></tr>
<tr><td rowspan="2">Parent/
Guardian
(If you are 16 years or younger)</td><td colspan="2">Name</td><td colspan="2">Phone Number</td></tr>
<tr><td colspan="4">Relationship</td></tr>
<tr><td>Health Card:</td><td colspan="2">Number</td><td>Version Code</td><td>Expiry</td></tr>
<tr><td>Family Physician (Circle)</td><td>4th Ave

Dr A Cappelletti
Dr K Chow
Dr K Elliott
Dr TC Ho
Dr B Leibfried
Dr J Lukings
Dr K Swayze
Dr C Wickens
Dr S Yurkewich
Dr J Zammit-Maempel</td><td>145 Carlton

Dr V Bayley
Dr C Buetow
Dr A Butera
Dr B Kerley
Dr O Kolenchenko
Dr D Vujosevic</td><td>Glenridge

Dr R Harb
Dr A Mohamed

Pelham
Dr M Torigian</td><td>Virgil

Dr D Al-Jarrah
Dr T Bastedo
Dr S Durocher
Dr I Mahdy
Dr R O'Leary
Dr L Ricciardi
Dr F Viviers</td></tr>
<tr><td colspan="2">City of St. Catharines Staff</td><td colspan="3">Not a patient of the NNFHT</td></tr>
</table>

Flu Vaccine Questionnaire (please answer ALL questions)	**Yes**	**No**	**Comments**
Do you have any Covid symptoms? Fever>37.8/100, cough, SOB, sore throat, runny/stuffy nose, change in smell/taste, nausea/vomit, diarrhea, abdo pain, headache, pink eye, fatigue, muscle aches, decrease appetite (kids), worsening/change chronic condition, fast heart rate, low BP, delirium, increased falls			
Have you ever had a flu shot before?			
Have you ever had a serious reaction to a vaccine in the past?			

Have you ever fainted after a vaccine or with needles?			
Do you have any allergies? Are you allergic to Egg product/protein (severe)? Thimerosal? Formaldehyde? Triton?			
Have you ever had a history of Guillain-Barre Syndrome (GBS) within 6 weeks of a flu shot?			
Have any active neurological disorders?			FLULAVAL
Are you currently being treated for cancer or receiving cancer treatment, or have received a stem cell transplant?			Have you discussed the flu shot with your specialist?
Have you ever had a history of Oculo-Respiratory Syndrome (ORS)?			FLULAVAL
Do you have an acute fever or serious illness today or for the past 3 days?			
Do you have a bleeding disorder/hemophilia/low platelets? Or are you on any blood thinners?			
Are you pregnant or breast feeding?			

For Children (<16 years of age)	**Yes**	**No**	**Comments**
Has the child ever had the flu vaccine before?			
Does the child have asthma or history of wheezing?			

Patient Consent

I have read the influenza FAQs and understand the benefits, risks, side effects and contraindications. I consent for NNFHT staff to administer the Flu Vaccine to me today. By consenting to get my flu vaccine I will not hold liable any NNFHT staff and its agents from any and all possible reactions to the vaccine inclusive of possibility of reaction while driving.
I agree to remain in waiting area for 10-15 minutes after receiving my vaccine.

Print Name:___________________________________ **Date:** ____________________

FOR STAFF ONLY

Administered by:				
Vaccine Name:	Fluzone® Quadrivalent (>6mos)	☐ Fluzone® HIGH-DOSE (>65 yo)	FluLaval Tetra® (>6mos)	Afluria® Tetra (>5yo)
Dose: 0.5 ml	**Route of Injection:**			
Location: Left Deltoid Right Deltoid		Expiry:		
Notes:				