

Client Information			
Last Name:	First Name:		
Address:	City:	Postal Code:	
Emergency Contact Name:	Emergency Telephone Number:		
Personal Health Number (PHN):	Date of Birth (MM/DD/YYYY):		
Gender: <span style="margin-left: 100px;">Pregnant: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A</span>			
COVID-19 Screening Questionnaire		YES	NO
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?			
Other Health Information			
<input type="checkbox"/> My immune system is affected by a severe disease or medication. If checked, please specify: _____ <input type="checkbox"/> I have had a serious life-threatening allergic reaction. Please specify: _____ <input type="checkbox"/> I have received another vaccine in the last 4 weeks. Please specify: _____			
Consent <input type="checkbox"/> Client <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Representative			
<p>I understand the information in the HealthLink BC File(s) for the vaccine listed below. I understand the benefits and possible reactions of the vaccine and the risk of not getting immunized. I have been informed of any medical reason why the vaccine listed below should not be given to me/my child. I have had the opportunity to ask questions that were answered to my satisfaction. I understand this consent is valid for the vaccine listed below unless the consent is cancelled.</p> <input type="checkbox"/> I consent to receiving/for my child to receive, the vaccine listed below. <input type="checkbox"/> I agree that I may be asked to wait in the clinic/pharmacy for 15-20 minutes after getting the injection and will seek medical attention if needed. <input type="checkbox"/> I will report any adverse effects I experience to the immunizing pharmacist. <input type="checkbox"/> I consent for the information collected on this form to be provided to my Family Physician (or Physician of my choice) and to the Health Authority for entry into my immunization record. I understand the information will be used and disclosed in accordance with the <i>Freedom of Information and Protection of Privacy Act</i> and that summary statistical information may be reported to the Ministry of Health.			
Name (PRINT)		Phone	
Signature (Legal guardian or Representative, if applicable)		Date signed (YYYY/MM/DD)	
<input type="checkbox"/> Patient verbal consent provided.			
FOR PHARMACIST USE ONLY			
Vaccine Information			
Name of vaccine: _____ DIN: _____		PHARMACY LABEL	
Dose: _____ mL Site: LA <input type="checkbox"/> RA <input type="checkbox"/> Route: IM <input type="checkbox"/> SC <input type="checkbox"/> ID <input type="checkbox"/> IN <input type="checkbox"/>			
Lot #: _____			
Expiry date (YYYY/MM/DD): _____			
LA left arm; RA right arm; IM intramuscular; SC subcutaneous; ID intradermal; IN intranasal.			
Pharmacy Information			
Pharmacist signature: _____		License number: _____	
Date of administration (YYYY/MM/DD): _____		Time of administration: _____	
Client Response			
Before: Normal Yes <input type="checkbox"/> No <input type="checkbox"/> _____		15-30 mins post-administration: Normal Yes <input type="checkbox"/> No <input type="checkbox"/> _____	
During: Normal Yes <input type="checkbox"/> No <input type="checkbox"/> _____		Notes: _____	
Faxed to Public Health Unit: Yes <input type="checkbox"/> No <input type="checkbox"/>		Faxed to Physician: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of Public Health Unit & Fax #: _____		Name of Physician & Fax #: _____	