COVID-19/Influenza Immunization Record

Last Name	First Name	Initial	Sex
Provincial Health Care Number		Date of Birth (yyyy-Mon-dd)	
Address		Phone (Home)	
City	Postal Code	Phone (Other)	

Please answer the following:

1. Are you sick today? ☐ yes ☐ no
2. Do you have any allergies? ☐ yes ☐ no If yes, please list:
3. Have you ever had a serious/allergic reaction to a vaccine? ☐ yes ☐ no
4. Do you have any autoimmune conditions, or do you take immunosuppressive medications? ☐ yes ☐ no
5. COVID-19 vaccine only:
   Have you had a COVID-19 vaccine or a positive COVID test in the past 3 months? ☐ yes ☐ no

- I understand that the pharmacist has received appropriate training and is registered to administer injections by the Alberta College of Pharmacists. I understand the pharmacist will comply with all professional standards surrounding the administration of injections as well as general pharmacy practice. The pharmacist maintains current certification in CPR and Basic First Aid.
- I agree to remain at the location for 15 minutes after the injection as directed by the pharmacist.
- The pharmacist has provided me with information on the vaccine being administered and the injection procedure so that I understand the expected outcome/reaction, as well as possible side effects.
- In the event of an emergency, I authorize the pharmacist to administer epinephrine and/or apply necessary lifesaving procedures as an interim measure until medical support personnel arrive.
- In case of emergency please contact emergency services at 911.
- I have read and understand the above information.

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Patient signature (parent or guardian if minor)

COVID-19 Vaccine (pharmacist use only)	**Influenza Vaccine (pharmacist use only)**
☑ Informed consent Vaccine: ☐Moderna XBB.1.5 0.5 mL IM lot **037G23A** exp **08/24** ☐Moderna XBB.1.5 0.25 mL IM lot **037G23A** exp **08/24** ☐ Pfizer XBB.1.5 0.3 mL IM **lot HD9867 exp 10/24** Site: Deltoid ☐ Left ☐ Right	☑ Informed consent Vaccine: ☐Fluzone HD 0.7mL IM lot **U8165CA** exp **06/24** ☐Fluzone 0.5mL IM lot **U8164AA** exp **06/24** Site: Deltoid ☐ Left ☐ Right
Date vaccine given _____	Time of administration _____
Pharmacist's Name (printed)	**Pharmacist's Signature**