



Influenza/COVID 19 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.

Patient signature (parent or guardian if minor)

COVID-19 Vaccine (pharmacist use only)	Influenza Vaccine (pharmacist use only)
<input checked="" type="checkbox"/> Informed consent Vaccine: <input type="checkbox"/> Moderna KP2.1.5 0.5 mL IM lot AW3191B exp 06/25 <input type="checkbox"/> Moderna KP2.1.5 0.25 mL IM lot AW3191B exp 06/25 Site: Deltoid <input type="checkbox"/> Left <input type="checkbox"/> Right	<input checked="" type="checkbox"/> Informed consent Vaccine: <input type="checkbox"/> Fluzone HD 0.7mL IM lot U846188 exp 06/25 <input type="checkbox"/> Fluzone 0.5mL IM lot U8431AA exp 06/25 Site: Deltoid <input type="checkbox"/> Left <input type="checkbox"/> Right
Date vaccine given _____ Time of administration _____	
Pharmacist's Name (printed)	Pharmacist's Signature