DALHOUSIE UNIVERSITY
Inspiring Minds
Faculty of Health Professions

CONTINUING PHARMACY EDUCATION
Providing learning opportunities to enhance pharmacy practice and patient care.

Injection Assessment and Consent Form

PLEASE PRINT: Date: ____

Name: ____ Health Card Number: _____________________________
Address: ____ Phone Number: _____________________________
Date of Birth: _____/_____/_______ Sex: ________________ Weight: _______________
dd mm yyyy

Family Physician:_____________________________ Office Number: ____________________________________
Allergies: ____
Current Medications: ____

Please Answer the following questions:

Are you sick today? Yes ___ No___
Have you ever had a severe reaction following an injection? Yes ___ No___
If yes, please specify _____________________________________
Have you ever fainted following an injection? Yes ___ No___
Are you taking blood thinners? Yes ___ No___
Women only: are you pregnant? Yes ___ No___

If you are receiving a vaccine, please answer the following additional questions:

Do you have a disease, which lowers immunity? (E.g. cancer, HIV, AIDS, etc.) Yes ___ No___
Are you taking a treatment that lowers immunity? Yes ___ No___
E.g.: oral steroid medicines (prednisone), radiotherapy, chemotherapy
Have you had other vaccines in the last month? Yes ___ No___
If yes, please specify ____________________________________
Have you had an injection of immunoglobulin or a blood transfusion within The last 3 months? Yes ___ No___

I understand that today I will have the following medications/vaccines administered:

Medication/Vaccine Name	**Dose**	**Purpose**

I authorize the pharmacist to notify my family physician of the injection(s): Yes ___ No ___

I understand and agree to remain at the location for 15 to 30 minutes after the injection(s) as directed by the pharmacist. Yes ___ No___

The pharmacist has provided me with information regarding the medication(s). I have read and understand the benefits and possible adverse reactions of the medication(s) being administered by injection and the risk of not receiving the medication(s). I understand that I may, at any time, before, during, or after the injection, ask the pharmacist further questions. In the event of an emergency, I authorize the pharmacist to administer epinephrine and/or apply necessary life saving procedures (including, but not limited to cardiopulmonary resuscitation (CPR)), as an interim measure until medical support personnel arrive.

In case of emergency, please contact ____________________________________ (name), ________________________(relation) at ___________________________(telephone, cell number, other)

The information on this form is true to the best of my knowledge. As with administration of any drug related product, there is the risk for reaction, including severe anaphylactic allergic reactions. I am aware of this risk and do not hold responsible the person administering the drug, the pharmacy, or any other staff for any adverse reaction due to the administration of this vaccine/drug. I provide consent and willingly volunteer to receive this vaccine/drug. I have read and understand all of the above information.

Signature: ___________________________________ Printed Name: _______________________________
(Parent or Guardian if Required)

Date: ______________________________________

Consent for follow-up injections:

Date	Medication	Dose Number ___ of ___	Administered by (Pharmacist Initials)	Any change(s) to previous information provided above? If yes, provide details.	Patient Initials

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