Data collection form

Section 1: Patient Information			Date (day/month/year):
Name:	First name:	RAMQ card number:	
Main phone number:	Date of birth (day/month/year):	Sex: ☐ M ☐ F	Age:
Full address:			
Person to contact in case of emergency:	Link with the patient:	Phone number of the person to contact in case of emergency:	
Allergy(s):			
Medication:			

Section 2: Screening Questionnaire	Yes	No
1. Do you have symptoms of Covid-19 or have you been in contact with someone who has Covid-19?		
2. Do you have Covid-19 or are you awaiting a test for Covid-19?		
3. Did you have a severe allergic reaction during a previous vaccination?		
4. Do you suffer from known allergies (Thimerosal, latex, others)?		
5. Have you ever had an allergic reaction to eggs or products that contain eggs?		
6. Do you have a bleeding disorder or do you take anticoagulants (e.g. warfarin)?		
7. Do you have a seizure disorder or a neurological problem?		
8. Have you ever suffered from Guillain-Barré syndrome or oculo-respiratory syndrome?		
9. Had you had any severe local reactions (accompanied by fever or not) when administering a dose of tetanus vaccine?		
Section 3: Vaccination is recommended and offered free of charge to those who meet the following criteria. (If not, a fee applies.)	Yes - Free	No = $
A. Is the vaccine for a healthy 6- to 23-month-old child?		
B. Are you a healthy person between the ages of 60 and 74?		
C. Are you 75 years of age or older?		
D. Are you pregnant? Number of weeks: _____(13 weeks and more, free vaccine)		
E. Are you under the age of 18 and are you taking a medication containing acetylsalicylic acid (ASA)?		
F. Are you a health care worker?		
G. Do you have one of the following chronic diseases?		
✓ Chronic heart or lung disorders (e.g., COPD, asthma, cystic fibrosis)		
✓ Diabetes or other chronic metabolic disorders		
✓ Liver problems, including cirrhosis		
✓ Kidney disorders		
✓ Hematological disorders, including hemoglobinopathy		
✓ Cancer		
✓ Immune deficiencies, including HIV infection		
✓ Immunosuppression caused by radiotherapy, chemotherapy, or anti-rejection drugs (transplant)		
✓ Convulsive, cognitive disorders, neurological problem, morbid obesity?		
H. Do you live under the same roof as a child under 6 months of age?		
I. Do you live under the same roof, or do you take care of someone with one of the conditions mentioned above? (Age, pregnant woman, chronic illness, high risk of hospitalization or death, senior's residence or long term care facility).		

Section 4: Consent granted by patient or guardian

I acknowledge that I have received all the information about the flu vaccine, and I agree to get vaccinated. I agree to wait in the pharmacy for a minimum of 15 minutes after receiving the vaccine.

I confirm that I/my child wishes to receive the vaccine against ☐ seasonal flu/☐ pneumococcal disease/☐other: _____

Patient's or guardian's name (and relationship with patient)	Patient or guardian signature	Date (day/month/year)

RESERVED FOR THE PROFESSIONAL Section 5: Vaccine used

HEALTH PROFESSIONAL STATEMENT:

☐I confirm that the patient named above is ability to provide consent for the administration of the vaccine.

Put the vaccine sticker on:	Lot number of vaccine:	The expiry date of the vaccine (month/year)

Immunization Date (day/month/year):	Immunization Hour:	Health professional name and signature: License number:

Injection site: ☐ Left arm ☐ right arm ☐ Intranasal