**Townline Pharmacy**
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# Flu/Covid-19 Vaccination Screening Form

| Section 1. Personal Information | | |
|---|---|---|
| **First Name:** | **Last Name:** | **Age:** |
| **Health Card #:** | | |
| Patient Phone Number: | | |
| Emergency Contact & Phone Number: | | |

| Section 2. Vaccine Screening Questionnaire | |
|---|---|
| 1. Are you currently **sick** today? (fever > 39.5 C, breathing problems, or active infection) | ☐ Yes ☐ No |
| 2. Do you/your child have any **allergies** to chemicals, medications, food, vaccine components, or latex?<br>● *If yes, please specify:* | ☐ Yes ☐ No |
| 3. Have you/your child ever had **a severe, life threatening reaction** to a vaccine, or have you/your child experienced wheezing, chest tightness, or difficulty breathing within 24 hours of having a vaccine? | ☐ Yes ☐ No |
| 4. Have you/your child ever had a reaction to **eggs or egg products** but can still eat small amounts of egg? (e.g. stomach ache, skin reaction) | ☐ Yes ☐ No |
| 5. Have you/your child ever experienced **adverse events** (ie. fainting, nausea, vomiting) following a vaccine? | ☐ Yes ☐ No |
| 6. Have you/your child ever had a **seizure** or a **brain/nervous system problem**? | ☐ Yes ☐ No |
| 7. Have you/your child ever had a history of **Guillain-Barre syndrome**? | ☐ Yes ☐ No |
| 8. Do you/your child have a **bleeding problem** or use **blood thinners**? | ☐ Yes ☐ No |
| 9. Have you /your child received any **other vaccines** in the **past 4 weeks**?<br>● *If yes, please specify:* | ☐ Yes ☐ No |