PRINCE EDWARD ISLAND
COLLEGE OF PHARMACISTS
Member organization of National Association of Pharmacy Regulatory Authorities (NAPRA)

Patient Consent Medication Administration by Injection

Date:_____ Patient Name:_____

Patient Date of Birth: ____/_____/_____ Gender: ☐ Male ☐ Female Weight:_____
Day/Month/Year

Address:_____ PHN:_____

Postal Code:_____ Home Phone: _____ Cell Phone:_____

Family Physician:_____ Emergency Contact Name and Phone:_____
Name Phone

Please select one of the following: ☐ Pregnant ☐ Aboriginal ☐ >65 yrs ☐ Direct household contact of a pregnant women ☐ None of the above

	Yes/No	If yes, please describe
Are you sick today?		
Do you have any allergies to drugs, thimersol, latex eggs, or fruits of any kind?		
Have you received this injection before?		
Have you received any vaccination in the last 6 weeks		
Have you ever had a serious reaction or fainted following and injection?		
Do you have any condition that affects your immune system such as cancer, HIV/AIDS?		
Do you take any treatments that may lower your immune system such as oral steroids (i.e. prednisone), radiotherapy or chemotherapy?		
If you brought your own medication/vaccine with you today, was is stored according to the package/pharmacists instructions		

☐ I understand that on the date indicated above, the pharmacist will be administering the drug

☐ I understand that the pharmacist has been trained and is registered to administer injections by the Prince Edward Island College of Pharmacists.

☐ Understand that, if required by provincial regulations, my primary health care provider and/or the Chief Public Health Office will be notified that I have received this injection.

☐ I understand and agree to remain at this location for 15-30 minutes after the injection as directed by the pharmacist.

☐ The pharmacist has provided me with information pertaining to the drug being administered as well as the injection procedure so that I understand the expected outcome/reaction as well as the possible side effects. I understand that I may ask the pharmacist further questions at any time before, during, or after the injection.

☐ In the event of an emergency, I authorize the pharmacist to administer diphenhydramine, epinephrine and/or apply necessary life saving procedures as an interim measure until medical support personnel arrive. In case of emergency please contact the person I have named above.

☐ I have read and understand the above information.

_____

Print Patient Name *Signature (parent or guardian if a minor)*

_____

Pharmacist Name Print *Signature of Pharmacist*