Servirplus
Mon choix pour la vie.

VACCINATION 2020
MEDICAL FILE

Société enregistrée Iso 9001

PERSON TO VACCINATE – SHORT SLEEVES REQUIRED PLEASE

Please complete the form in block letters

INFORMATION AS LISTED IN YOUR MEDICAL FILE: RAMQ NUMBER (Qc only) ____________ | ____________
LETTERS NUMBERS

LAST NAME : ______________________ NAME : ______________________

ADDRESS : ______________________ BIRTH DATE: ____________
yyyy-mm-dd

VACCINATION SITE:

EMPLOYER OR PHARMACY NAME : ______________________

ADRESS OF EMPLOYER OR PHARMACY : ______________________

ALLERGIES:

- Thimerosal (solution for contact lenses) No ☐ Yes ☐
- Neomycin No ☐ Yes ☐

IF YES, YOU CANNOT BE VACCINATED

OTHERS ALLERGIES : ______________________
(If in doubt, check with your doctor if there are any contraindications)

HAVE YOU EVER RECEIVED THE FLU VACCINE ? No ☐ Yes ☐

HAVE YOU EVER HAD AN ADVERSE REACTION ?
(EX : severe breathing difficulty, swallowing difficulty, facial swelling, guillain barré) No ☐ Yes ☐

IF YES, WHAT REACTION ? EXPLAIN. ______________________

DO YOU HAVE BLOOD CLOT PROBLEMS ? No ☐ Yes ☐

DO YOU HAVE FEVER TODAY ? No ☐ Yes ☐

DO YOU HAVE AN ALLERGY TO LATEX ? No ☐ Yes ☐

ARE YOU PREGNANT? No ☐ Yes ☐

A CHANGE IN YOUR HEALTH CONDITION? ______________________ No ☐ Yes ☐

ENGAGEMENT CONTRACT

I have received and read all the information concerning the vaccine and the obligation of remaining for observation for 15 minutes after the administration of the vaccine. If I leave prior to the required time, I assume "full responsibility" for the consequences of an adverse reaction that may occur thus relieving the nurse and my employer of all responsibility.

Signature : ______________________ Date : ____________ Time : ____________
☐ Patient ☐ Parent ☐ Tutor

In case of major subsequent reaction, please contact your supervisor who will notify Servirplus.

NURSE'S SECTION

VACCINE	DATE	TIME	INJECTION			SITE	
Quadrivalent (Afluria Tetra)	____	____	Lot : # ______	0.5 ml	I/M	Right arm ☐	Left arm ☐
Flucelvax	____	____	Lot : # ______	0.5 ml	I/M	Right arm ☐	Left arm ☐

Nurse signature : ______________________ Permit nb : ______________________