



**Waverley Road PharmaChoice**  
**249-5 Waverley Road, Dartmouth, NS B2X 2C5**  
**Tel: [902-406-9779](tel:902-406-9779) Fax: [902-406-9499](tel:902-406-9499)**

PLEASE PRINT

NAME: \_\_\_\_\_

\_\_\_\_\_ MALE / FEMALE

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_/ HEALTH  
CARD # \_\_\_\_-\_\_\_\_-\_\_\_\_-\_\_\_\_  
                    D      M      Y      \_\_\_\_ (if not a  
                    customer here)

Telephone: (Home) \_\_\_\_\_  
(Cell) \_\_\_\_\_

Street  
Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_  
Postal Code: \_\_\_\_\_

Family Doctor's Name: \_\_\_\_\_

Please answer the following questions.



### Edit with the Docs app

Make tweaks, leave comments, and share with others to edit at the same time.

NO THANKS

GET THE APP

6. Are you on Aspirin or blood thinners? YES / NO

### Acknowledgement and Waiver

I, the undersigned, wish to receive a vaccination against influenza. I am taking this vaccine voluntarily and consent to the vaccination being given to me. I have read the information provided. I have had the opportunity to ask questions and to have them answered to my satisfaction. I am aware of the strong recommendation to remain in the clinic for 15-30 minutes after receiving the vaccine. I hereby waive any claim for damages that I (or anyone claiming on my behalf) may have against this pharmacy, its directors, employees and agents on account of any injury or misfortune I may suffer as a result of this vaccination. In the event of an emergent situation, I give consent to the Pharmacist to administer epinephrine and/or perform life saving procedures until medical personnel arrive on scene.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### Pharmacist Only:

Vaccine: **Fluzone** / **FluLaval** Manufacturer: \_\_\_\_\_  
Lot#: \_\_\_\_\_ Exp: \_\_\_\_\_

Dosage: **0.5mL** / **1.0mL** Arm: **R** / **L**

Date (as above); Administrator's Name,  
Title: \_\_\_\_\_  
Signature: \_\_\_\_\_

WAVERLEY ROAD

