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

Patient Consent: Medication Administration

Date: _____ Patient Name: _____

Patient date of birth: ____/____/____ Gender: ☐ Male ☐ Female Weight: _____ PHN: _____
Day/Month/Year

Address: _____ Postal Code: _____

Phone Number(s): _____

Primary Care Provider: _____

Emergency Contact Name/Phone Number: _____

	Yes/No	If yes, please describe
Are you sick today?		
Do you have any allergies to drugs, thimerosal, latex, eggs or fruit of any kind?		
If you brought your own medication/vaccine with you today, was it stored according to the package/pharmacist's instructions?		
For vaccinations:		
Have you received any vaccinations in the last six weeks?		
Do you have any condition that affects your immune system (i.e. cancer or HIV/AIDS)?		
Do you take any treatments that may lower your immune system such as oral steroids (i.e. prednisone), radiotherapy, or chemotherapy?		
For injections: Have you ever had a serious reaction or fainted following an injection?		

☐ 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 Pharmacy.

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

☐ I understand that I am expected to remain at this location for monitoring after the administration as directed by the pharmacist.

☐ The pharmacist has provided me with information pertaining to the drug being administered as well as the administration 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 administration.

☐ 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 support personnel arrive. In case of emergency, please contact the person I have named above.

_____ _____

Print Patient Name

Patient Signature (parent/guardian if a minor) OR
Pharmacist Signature indicating verbal consent