

Medical Directive

Administration of Influenza Vaccine to TVFHT Staff and Affiliates	Assigned Number: 027
Activation Date: July 1, 2011	Review Due By: October 2027
Approval Signature & Date	
Medical Director: 	Date Reviewed: October 19, 2026
Executive Director of Clinical Services: 	Date Reviewed: October 19, 2026
Order and/or Delegated Procedure:	Appendix Attached: ☐ Yes ☒ No
Administration of the seasonal influenza vaccine to Thames Valley Family Health Team (TVFHT) staff and affiliates.	
Recipients:	Appendix Attached: ☐ Yes ☒ No
All TVFHT staff, affiliated physicians, and the physicians' employees (excluding contractors or contracted workers who are members of a third-party contract or under direct contract with TVFHT).	
Authorized Implementers:	Appendix Attached: ☐ Yes ☒ No
TVFHT Registered Nurses/Registered Practical Nurses (RN/RPN) The implementer must complete educational requirements for this medical directive, including review of the education package and medical directive and successful completion of any quizzes. If additional orientation or shadowing is needed, the implementer must make arrangements for this with their clinical supervisor. Once all of the above has been completed, they are required to sign the Implementer Performance Readiness Form electronically, via Citation Canada, indicating they have the knowledge, skill and judgment to safely enact the medical directive. The Implementer must be an active Implementer for Medical Directive 007: Emergency Treatment of Anaphylaxis/Severe Allergic Reactions to Allergy Injections, Vaccines, or Injectable Medications prior to utilizing this directive.	
Indications:	Appendix Attached: ☐ Yes ☒ No
TVFHT staff or affiliate is due for their annual influenza vaccine.	
Contraindications:	Appendix Attached: ☐ Yes ☒ No
Contraindications as outlined in the most recent National Advisory Committee of Immunizations: Statement on seasonal influenza vaccines for 2026–2027 - Canada.ca	

Consent:	Appendix Attached: ☒ Yes ☐ No Title: Appendix 1: Health Care Provider Influenza Vaccine Consent Form 2026-2027
Written informed consent is obtained using the 2026–2027 Health Care Provider Influenza Vaccine Consent Form (Appendix 1), prior to the implementation of care.	
Guidelines for Implementing the Order/ Procedure:	Appendix Attached: ☒ Yes ☐ No Title: Appendix 1: Health Care Provider Influenza Vaccine Consent Form 2026-2027
1. Determine and confirm the appropriate seasonal influenza vaccine to be administered per the Statement on seasonal influenza vaccines for 2026–2027 - Canada.ca 2. Follow best practice guidelines and the steps outlined in the Vaccine administration practices section of the Canadian Immunization Guide. 3. Monitor vaccine recipient for any signs or symptoms of an adverse reaction for 15 minutes following the injection. In case of anaphylaxis or severe allergic reaction, implement TVFHT Medical Directive 007: Emergency Treatment of Anaphylaxis/Severe Allergic Reactions to Allergy Injections, Vaccines, or Injectable Medications.	
Documentation and Communication:	Appendix Attached: ☒ Yes ☐ No Title: Appendix 1: Health Care Provider Influenza Vaccine Consent Form 2026-2027
• The implementer will follow the documentation standards set by their governing college. • Document using the Health Care Provider Influenza Vaccine Consent Form 2026-2027. • The completed form is given to the vaccine recipient for their personal records—they are encouraged to upload a copy to Citation Canada as proof of annual vaccination.	
Review and Quality Monitoring Guidelines:	Appendix Attached: ☐ Yes ☒ No
The directive remains in effect until amended. It will be reviewed annually or under the following circumstances: 1. The Medical Director identifies a need for change 2. Issues arise related to the directive's use—the team must promptly communicate concerns to their clinical supervisor, Medical Directives Coordinator, or Clinical Director 3. New information becomes available between scheduled reviews, particularly if it affects outcomes The Medical Directives Committee will then review the concerns in consultation with at least one implementer and the Medical Director, as needed, before making necessary changes.	
Approving Authorizer(s):	Appendix Attached: ☐ Yes ☒ No
TVFHT Medical Director – authorization recorded in Citation Canada.	



Appendix 1:

INFLUENZA VACCINE CONSENT FORM 2026-2027

Last name: _____ First name: _____ Phone number: _____

Street Address: _____ City: _____ Postal Code: _____

Gender: ☐ Male ☐ Female ☐ Other Date of Birth: Year _____ Month _____ Day _____ Age: _____

Answer the following questions:

Is this person feeling sick today?	☐ YES ☐ NO
Has this person ever had a reaction to a vaccine including but not limited to: - Guillain-Barré Syndrome (GBS)? - Oculo-respiratory Syndrome (ORS)? - Severe allergic reaction?	☐ YES ☐ NO
Does this person have any allergies, including but not limited to: - Thimerosal? (multi-dose vials only) - Kanamycin and/or Neomycin? (Fluad only) - Formaldehyde? (Fluviral, Fluzone, Fluzone-HD and Fluad only)	☐ YES ☐ NO
Does this person have a bleeding disorder or take medications that affect blood clotting?	☐ Yes ☐ No
If the answer is "YES" to any question, please explain:	

Continue to answer the questions below if the person is a child between 6 months to less than 9 years old:

Has the child ever had a dose of flu vaccine before September 2026?	☐ YES ☐ NO
If no, is this the 1st or 2nd dose the child has had since September 2026?	☐ 1 st dose ☐ 2 nd dose
If this is the 2nd dose, what date did the child get their 1st dose?	Date: _____

Consent:

I have read (or it has been read to me) and I understand why this vaccine is recommended. I have had the opportunity to ask questions and have had them answered to my satisfaction. I consent to receiving the seasonal influenza vaccine. In addition, I am aware that the personal health information collected on this form may be shared with another healthcare provider if it is required for my care.

If signing for someone other than yourself, indicate your relationship to that person: _____

- If signing for someone other than myself, I confirm that I am the parent/legal guardian or substitute decision maker.

Signature: _____ Print: _____ Date: _____

For Clinic Use Only:

Vaccine	Dose (mL)	Lot #	Exp.	Site (IM)	Time	Date	Provider Signature
	0.5 mL						

Comments: _____