

Novel Coronavirus (COVID-19) Screening

Please answer the questions below:

Yes No Are you experiencing COVID-19 symptoms including fever, cough, difficulty breathing, or extreme tiredness?

Yes No Do you have a travel history outside of Manitoba in the last 14 days?

Yes No Have you had contact with a person who has a travel history (above) or has been confirmed to have COVID-19?

Client name _____

Parent/legal decision maker _____

Signature (client/parent or legal decision maker) _____

Date _____

The following section to be completed by pharmacy staff

Check this box if verbal consent has been obtained from client because they are unable to sign

Pharmacy staff signature _____

Region _____ Clinic Location _____ Date _____

SECTIONS A, B, C AND D COMPLETED BY:

Client _____ Parent _____ Legal decision maker _____ Other _____ (on behalf of client)

A. Client Information - please print

Surname _____ Given Names _____
 Address _____ City/Town _____ Postal Code _____
 Home Phone _____ Date of Birth (yyyy/mm/dd) ____ / ____ / ____ Gender Male Female
 Manitoba Health Number (6 digits) _____ Personal Health Information Number (9 digits) _____

B. Health History of Client

1. Are you well today? Yes No
 If no, describe _____
 2. Do you have any allergies? Yes No
 If yes, describe _____
 3. Have you ever had a serious reaction or condition following any vaccine? Yes No
 If yes, describe _____
 4. Do you have any conditions that require regular visits to a doctor? Yes No
 If yes, please discuss with immunizer _____
 5. Are you taking any medication that affects blood clotting? Yes No
 If yes, please list _____

C. Reason for Immunization – Please check the first reason that applies (Check ONE box only)

1. Health care worker 2. High risk 3. Contact of high risk 4. No known risk
 Health care workers only • indicate your primary work setting: Long-term care / PCH Community Acute
 • print your facility / office name _____

D. Informed Consent – Consult immunization provider if no signature can be obtained

I have read and understood the fact sheet(s) regarding the vaccine(s) that I am consenting be administered to the above named person as indicated below. I have had the opportunity to ask questions about the vaccine(s) which were answered to my satisfaction.

Complete ONLY ONE of the following two options:

1. Consent by parent or legal decision maker

I consent to the above named person receiving:
 Seasonal Influenza Vaccine Pneumococcal Vaccine
 Name _____
 Relationship _____
 Phone number _____
 Date _____
 Signature _____

2. Consent by client

I consent to receiving:
 Seasonal Influenza Vaccine Pneumococcal Vaccine
 Date _____
 Signature _____

Notice: Information about the immunizations you or your child(ren) receive may be recorded in the provincial immunization registry. This registry allows your health care providers to find out what immunizations you or your child(ren) have had or need to have. Information collected in the provincial immunization registry may be used to produce immunization records, or notify you or your doctor if a particular immunization has been missed. Manitoba Health, Seniors and Active Living may use the information to monitor how well different vaccines work in preventing disease. The Personal Health Information Act protects your information. You can have your personal health information hidden from view from health care providers. For more information, please contact your local public health office to speak with a public health nurse www.manitoba.ca/health/publichealth/offices.html.

THE FOLLOWING SECTION TO BE COMPLETED BY IMMUNIZATION PROVIDER

The following five interventions must be performed and documented with a check mark by the immunization provider:

1. Fact sheet(s) provided
2. Health history completed and reviewed
3. Expected benefits and material risks of vaccine provided
4. Information provided about reporting vaccine side effects (Reportable side effects pursuant to section 57(2) of the Public Health Act)
5. Concerns and questions addressed

Check this box if verbal consent has been obtained from client because they are unable to sign section D

Note: Manitoba Health recommends that written consent be obtained whenever possible.

Vaccine		Date Y/M/D	Lot #	Manufacturer	Dose	Route	Site	Immunization Provider's Signature	Data Entry
Seasonal Influenza	Dose 1								
	Dose 2								
Pneumococcal (Pneu-P-23)									