# Seasonal Influenza and Pneumococcal Immunization Consent Form

Manitoba

Clear All

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) | | | | | | | | | |