Manitoba

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COVID-19, Influenza, and Pneumococcal Immunization Consent Form

Region _____ Clinic Location _____ Date _____

SECTIONS A, B, C, D AND E COMPLETED BY:

☐ Client ☐ Parent/Guardian ☐ Legal or appointed decision maker

A. Client Information - please print

Last Name(s): _____ First Name(s): _____ Preferred Name(s): _____

Address: _____ City/Town: _____ Postal Code: _____

Date of Birth (yyyy/mm/dd): _____ / _____ / _____ Age: _____ Preferred Pronoun (s) e.g. she, he, they, etc.: _____

Manitoba Health Number (6 digits): _____ Personal Health Information Number (9 digits): _____

Phone Number: _____ Email: _____

B. Health History of Client

1. Are you well today? Yes ☐ No ☐

   If no, describe _____

2. Do you have any known or suspected 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 health conditions that require regular visits to a doctor? Yes ☐ No ☐

   If yes, describe _____

5. Are you taking any medication that affects blood clotting? Yes ☐ No ☐

   If yes, please list _____

6. Is your immune system suppressed due to an autoimmune condition (i.e. Rheumatoid Arthritis, Multiple Sclerosis) or disease (i.e. Leukemia) or treatment (i.e. high-dose steroids)? Yes ☐ No ☐

   If yes, please describe _____

7. Have you received a dose of a COVID-19 vaccine in the past 6 months? Yes ☐ No ☐

8. Have you had a confirmed COVID-19 infection in the last 6 months? Yes ☐ No ☐

   If yes, when? _____

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 care

• print your facility / office name _____

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

Complete ONLY ONE of the following two options:

1. Consent by client (including mature minor)

I consent to receiving:

☐ Standard-dose Influenza vaccine
☐ High-dose Influenza vaccine
☐ COVID-19 vaccine
☐ Pneumococcal vaccine (Pneu-C-20)

Date _____

Signature _____

Fact sheets regarding the benefits and risks of the vaccine(s) are available at: ***www.manitoba.ca/health/publichealth/cdc/div/vaccines.html***

I have read and understood the information regarding the risks and benefits of the vaccine(s) that I am consenting to, including potential common side effects of the vaccine(s). I have had the opportunity to ask questions about the vaccine(s) which were answered to my satisfaction.

2. Consent by parent/guardian or legal or appointed decision maker

I consent to the above-named person receiving:

☐ Standard-dose Influenza vaccine
☐ High-dose Influenza vaccine
☐ COVID-19 vaccine
☐ Pneumococcal vaccine (Pneu-C-20)

Name _____

Relationship _____

Phone number _____

Date _____

Signature _____