

Seasonal Influenza and Pneumococcal Vaccine Consent Form



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 your immunization will be recorded in the Manitoba Immunization Monitoring System (MIMS) and used for surveillance by Manitoba Health to produce immunization records, monitor vaccine uptake and how well vaccines are working, and may also be used for research. All information recorded in MIMS will be protected in accordance with the Protection of Privacy provisions of *The Personal Health Information Act*.

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	MIMS Entry
Seasonal Influenza	Dose 1							
	Dose 2							
Pneumococcal (Pneu-P-23)								