Manitoba

Print Save Clear

Administrative Use Only
Reviewer: _____
Date: _____

Adult Immunization Consent Form

Region: _____ Location : _____ Date: _____

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:	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, please describe: _____
2. Do you have any allergies? ☐ Yes ☐ No
   If yes, please describe: _____
3. Have you ever had a serious reaction or condition following any vaccine? ☐ Yes ☐ No
   If yes, please describe: _____
4. Do you have any health conditions that require regular visits to a doctor? ☐ Yes ☐ No
   If yes, please describe: _____
5. Do you have any conditions that can suppress your immune system (e.g., HIV, problems with spleen, organ transplant, etc.)? ☐ Yes ☐ No
   If yes, please describe: _____
6. Are you taking any medications and/or have you recently received or are you receiving any medical treatment (e.g., steroids, chemotherapy, radiotherapy, immune globulin therapy etc.)? ☐ Yes ☐ No
   If yes, please list: _____
7. Have you received any vaccines in the past four (4) weeks? ☐ Yes ☐ No
   If yes, please describe: _____
8. Are you pregnant, planning to become pregnant, and/or breastfeeding? ☐ Yes ☐ No ☐ N/A

C. Reason for Immunization – To be completed only in Long-Term Care facilities and hospital settings, and/or for occupational health purposes. Please check ONE box only.

1. ☐ Occupational hazard (health care worker, volunteer) 2. ☐ Personal Care Home resident 3. ☐ High risk environment (hospital) 4. ☐ Routine (visitors)

Health care workers only - indicate your primary work setting: ☐ Long-term care ☐ Community ☐ Acute Care

Print your facility/ office name _____

D. The following vaccines will be provided: *(Section to be completed by the health-care provider)*

☐ Hepatitis A (HAV)	☐ Pneumococcal conjugate (Pneu-C-20)
☐ Hepatitis B (HBV)	☐ Rabies
☐ Hepatitis B immune globulin (HBIG)	☐ Rabies immune globulin (RIG)
☐ Human Papillomavirus (HPV)	☐ Tetanus, Diphtheria and acellular Pertussis (Tdap)
☐ Inactivated polio (IPV)	☐ Varicella (chickenpox)
☐ Measles, mumps, rubella (MMR)	☐ Other
☐ Meningococcal B (4CMenB)	☐ Other
☐ Meningococcal conjugate ACYW(Men-C-ACYW)	☐ Other

E. Informed Consent – Consult immunization provider if no signature can be obtained. **Complete ONLY ONE of the following two options:**

1. Consent by client

☐ **YES** – I consent to receive the vaccine(s) selected in Section D

☐ **YES** – I consent to receive the vaccine(s) selected in Section D, except:

_____
Please indicate which vaccine(s) you do NOT consent to

☐ **NO** – **I DO NOT** consent to receive the vaccine(s) selected in Section D.

If possible, please explain the reason why: _____

Date: _____

Signature: _____

Consent by legal or appointed decision-maker

☐ **YES** – I consent to the above-named person receiving the vaccine(s) selected in Section D

☐ **YES** – I consent to the above-named person receiving the vaccine(s) selected in Section D except:

_____
Indicate which vaccine(s) you do NOT consent to the above-named person receiving.

☐ **NO** – **I DO NOT** consent to the above-named person receiving the vaccine(s) selected in Section D

If possible, please explain the reason why: _____

Name: _____

Relationship: _____ Phone number: _____

Email: _____

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 understood the information regarding the risks and benefits of the vaccine(s) that I am consenting to, including potential side effects of the vaccine(s). Some vaccines require more than one dose within the year, my consent applies to all doses of the vaccine(s) necessary to complete the series for up to one year unless I withdraw my consent. I have had the opportunity to ask questions about the vaccine(s) which were answered to my satisfaction.

Name of client: _____ PHIN #: _____

Notice: The Department of Health is authorized to collect the personal information and personal health information on this form by s. 13(1) of The Personal Health Information Act and s. 36(1)(b) of The Freedom of Information and Protection of Privacy Act because it is collected for the purpose of administering immunizations. Information about the immunizations you receive will be recorded in the provincial immunization registry. Information collected in the provincial immunization registry can be used to produce immunization records or notify you or your doctor if a particular immunization has been missed. The Personal Health Information Act protects your information. You can have your personal health information hidden from the view of health care providers. For more information please refer to **www.manitoba.ca/health/publichealth/surveillance/phims.html** or contact your local public health office to speak with a public health nurse **www.manitoba.ca/health/publichealth/offices.html**.

F. Racial, Ethnic or Indigenous Identity

Since May 2020, public health has been collecting information about the racial, ethnic, and Indigenous identity of individuals. The following questions will help assess vaccine coverage and determine the need for increased vaccine accessibility in different communities. We recognize that this list of racial or ethnic identifiers may not exactly match how you would describe yourself. Please check the racial or ethnic community that best describes you:

☐ African ☐ Black ☐ Chinese ☐ Filipino ☐ Latin American ☐ South Asian ☐ Southeast Asian ☐ White
☐ North American Indigenous (First Nation, Métis, Inuit) ☐ Other ☐ Prefer not to answer

If you identified as North American Indigenous, please check the group you identify as:

☐ First Nations ☐ Métis ☐ Inuit

THE FOLLOWING SECTION TO BE COMPLETED BY THE IMMUNIZATION PROVIDER

Verbal Consent			
Date:_____/____/____ (yyyy/mm/dd)	Name:	Relationship (legal or appointed decision maker/ client):	Health-Care Provider Signature:

Consent Using an Interpreter		
Interpreter's Name or ID#:	Phone:	Date:_____/____/____ (yyyy/mm/dd)

Date yyyy/mm/dd	Vaccine	Lot #	Manufacturer	Dose	Route	Site	Immunizer's Signature	Data Entry

Supplementary Information
All entries must be signed

Date yyyy/mm/dd	Notes:

THE FOLLOWING SECTION IS FOR TUBERCULIN SKIN TESTING

Consent by client

☐ **YES** – I consent to receive the Tuberculin Skin Test (TST)
Date: _____
Signature : _____

☐ **NO** – I do not consent to receive the Tuberculin Skin Test (TST)
If possible, please explain the reason why: _____
Date: _____
Signature : _____

Tuberculin Skin Test

Date yyyy/mm/dd	Time planted HH:MM	Lot #	Manufacturer	Dose	Route	Site	Date Read yyyy/mm/dd	Time HH:MM	Result (Include TST Read in mm)	Immunizer's Signature	Data Entry