

# Pandemic H1N1 Influenza, Seasonal Influenza & Pneumococcal Vaccine Surveillance/Consent Form



REGION: \_\_\_\_\_ CLINIC LOCATION: \_\_\_\_\_ DATE: \_\_\_\_\_

**CLIENT INFORMATION:**

PHIN (9#'s) \_\_\_\_\_  
 MHSC (6#'s) \_\_\_\_\_  
 Other \_\_\_\_\_

Date of Birth M  F   
 \_\_\_/\_\_\_/\_\_\_  
 yyyy/mm/dd

Surname \_\_\_\_\_ First name \_\_\_\_\_ Initial \_\_\_\_\_

Home Address (Apt/Street/Box#) \_\_\_\_\_ City/Town \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone Number \_\_\_\_\_

**HEALTH HISTORY/ INFORMATION**

- Completed By:**  CLIENT  PARENT  LEGAL DECISION-MAKER  HEALTH CARE PROVIDER FOR CLIENT
- Are you well today?  Yes  No If yes go to question 3.
  - Do you currently have a high fever?  Yes  No
  - Do you have a condition that requires you to see the doctor regularly?  Yes  No
  - Are you taking any medication regularly?  Yes  No
  - Are you on any medication that affects blood clotting? Have you had recent bleeding or bruising?  Yes  No
  - Have you had a previous lab-confirmed diagnosis of pH1N1 influenza?  Yes  No
  - Have you ever had a severe allergic reaction to any vaccine or element of a vaccine (see relevant fact sheet), including seasonal influenza vaccine?  Yes  No
  - Do you have hypersensitivity to eggs? (ex. hives, swelling of mouth &/or throat, breathing difficulty)  Yes  No
  - Do you have any other allergies?  Yes  No
  - Have you experienced Guillain-Barré Syndrome within eight weeks of receiving an influenza vaccine?  Yes  No
  - Could you be pregnant or are you considering becoming pregnant within one month?  Yes  No
  - Is there anything else the nurse should know before deciding if you should get the vaccine?  Yes  No

If YES to any of the above, please tell nurse.

**REASONS FOR PH1N1 IMMUNIZATION (OTHER THAN AGE): (See Guidelines for Pandemic H1N1 {pH1N1} Vaccine)**

\*\*\* Please check ALL that apply \*\*\*

- |  |   |
|--|---|
| <input type="checkbox"/> Chronic condition (including heart, lung or kidney disease; diabetes; cancer; anemia or weakened immune system; or people whose chronic condition has been made worse by previous viral infections) | <input type="checkbox"/> Household contacts and/or care providers of infants <6 months                  |
| <input type="checkbox"/> Pregnant  | <input type="checkbox"/> Household contacts and/or care providers of persons who are immuno-compromised |
| <input type="checkbox"/> Aboriginal ancestry (First Nations, Métis, Inuit)   | <input type="checkbox"/> Critical infrastructure worker   |
| <input type="checkbox"/> Other risk conditions (e.g. homeless, refugee, recent immigrant, poverty etc.)  | <input type="checkbox"/> Person who works directly with poultry or swine                                |
| <input type="checkbox"/> Health care worker/medical first responder  | <input type="checkbox"/> No known risk factor   |
|  | <input type="checkbox"/> Other _____  |

**Notice:** Information about your immunization will be recorded in the Manitoba Immunization Monitoring System (MIMS) and used for surveillance by Manitoba Health and Healthy Living 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*.

**Written Consent by Parent or Legal Decision Maker for Immunization:**

I have read and understood the fact sheet(s) respecting 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.

**YES, I do consent to the above named person receiving the:**

- pH1N1 Influenza Vaccine  Seasonal Influenza Vaccine  Pneumococcal Vaccine

Signature \_\_\_\_\_ Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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## Verbal Consent by Client for Immunization:

The above client has been provided with a copy of the fact sheet(s) respecting the vaccine(s) as indicated below. The client was provided with the opportunity to ask questions about the vaccine(s) which were answered and consents to receiving the:

- pH1N1 Vaccine
  Seasonal Influenza Vaccine
  Pneumococcal Vaccine

Health Care Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

## FOR IMMUNIZATION PROVIDER USE ONLY

Informed consent provided by:  Client  Parent/legal decision-maker

## Immunization Interventions: Initial and date completed intervention(s)

- Health history completed & reviewed
  Information provided to report vaccine side effect\*

- Fact sheet(s) provided & reviewed

\* Reportable side effects pursuant to section 57(2) of the Public Health Act

- Information about the vaccine expected benefits and material risks provided & reviewed

**Sufficient assessment to proceed with immunization**

- Concerns & questions addressed

**Vaccination not given due to:**

- Contraindication  
 Possible Contraindication  
 Vaccination delayed

Reason/Comment \_\_\_\_\_

Nurse's Initials \_\_\_\_\_ Date: \_\_\_\_\_

## Pandemic H1N1 Vaccine:

<p><b>Site:</b> Left (L) <input type="checkbox"/> Right (R) <input type="checkbox"/></p> <p><b>Route (IM):</b> Vastus Lateralis (VL) <input type="checkbox"/> Deltoid (D) <input type="checkbox"/></p> <p><b>Dose:</b> <input type="checkbox"/> 0.5 ml <input type="checkbox"/> 0.25 ml</p> <p><b>Manufacturer:</b> _____</p> <p><b>Provider Signature</b> _____</p>	<p><b>Dose #1</b> <input type="checkbox"/> <b>Dose #2</b> <input type="checkbox"/></p> <p><input type="checkbox"/> Adjuvanted <input type="checkbox"/> Unadjuvanted</p> <p>Lot # Antigen: _____ Expiry date: _____</p> <p>Lot # Adjuvant: _____ Expiry date: _____</p> <p>Lot # Shoe box (Antigen+Adjuvant): _____</p> <p><b>MIMS Data Entry Date</b> _____ <b>Initials</b> _____</p>
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## Seasonal Influenza Vaccine and/or Pneumococcal Vaccine:

Vaccine	Dose	Lot #	Manufacturer	Expiry date	Site				Provider Signature	MIMS Data Entry: Date & Initials
					L	R	VL	D		
Pneumo.										
Seasonal Influenza										

## Reason for Seasonal Influenza and/or Pneumococcal Vaccine:

- Health care worker
  Household contact
  High risk
  No risk