

# Adult Immunization Consent Form



Name: \_\_\_\_\_ Home address: \_\_\_\_\_

Telephone number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Year/month/day

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
9 Digit Manitoba Health Number (PHIN#)

Health History completed by: Client  Health Care Provider  Legal Decision-Maker

1. Are you well today?  Yes  No (If no, describe): \_\_\_\_\_ Date: \_\_\_\_\_

2. Do you have any allergies?  Yes  No (If yes, describe): \_\_\_\_\_ Date: \_\_\_\_\_

3. Do you have any health conditions that require regular visits to a doctor?  Yes  No (If yes, describe): \_\_\_\_\_

4. Do you have any conditions that can suppress your immune system (i.e., HIV infection, problems with spleen, organ transplant, etc)?  Yes  No (If yes, describe): \_\_\_\_\_

*Note: Tell the nurse or doctor if you are taking treatment, i.e., steroids, chemotherapy, radiotherapy, etc.*

5. Have you experienced a reaction to a vaccine in the past?  Yes  No (If yes, describe): \_\_\_\_\_

6. Are you pregnant or considering becoming pregnant within one month?  Yes  No  N/A

\*Legal decision-maker's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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.gov.mb.ca/health/publichealth/offices.html](http://www.gov.mb.ca/health/publichealth/offices.html).

## Section to be completed by the immunization provider:

### Verbal Consent:

The legal decision-maker has been made aware of the benefits and the risks of the vaccine(s) offered to the above person and consents for the identified person to be immunized on the following date: \_\_\_\_\_

The legal decision-maker has agreed to complete the Adult Immunization Consent Form provided to him/her and agreed to forward the completed form to this immunization provider. Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

### The following vaccine(s) will be given: Indicate with a check (✓)

**Td** - tetanus, diphtheria

**MMR** - measles, mumps, rubella

**Hepatitis A** (series)

**Hepatitis B** (series)

**Hepatitis A & B** (series)

**Influenza**

**Pneumococcal** (conjugate or polysaccharide)

**Cholera**

**Other:** \_\_\_\_\_

**IPV** - inactivated polio

**Rabies** (series)

**HRIG** - Human Rabies Immune Globulin

**HBIG** - Hepatitis B Immune Globulin

**Meningococcal** (conjugate or polysaccharide)

**Varicella**

**Typhoid** (oral or injectable)

**Tdap** - tetanus, diphtheria, pertussis

**Other:** \_\_\_\_\_

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

Provided and reviewed fact sheet(s) Date: \_\_\_\_\_ Explained to report vaccine side effects Date: \_\_\_\_\_

Answered questions and concerns Date: \_\_\_\_\_ Other: \_\_\_\_\_ Date: \_\_\_\_\_

Immunization record given to client Date: \_\_\_\_\_ Health history completed Date: \_\_\_\_\_

**Section to be completed by the immunization provider:**

Name of client: \_\_\_\_\_ PHIN #: \_\_\_\_\_

**Immunization Record: The vaccine(s) identified below were administered:**

Vaccine	Number in series	Manufacturer	Lot #	Site	Route	Dose	Date y/m/d	Provider signature	Data entry	Clerk's initials

**TB Skin Test**

Mantoux	Date Planted	Lot #	Dose/Route/Site	Initial	Date Read	Positive	Negative	Initial

**Supplementary Information**

Date	Notes (include immunization refusal)	Signature

**Important Immunization Tips:**

*Before*

- √ Vaccine storage and handling practice as per the manufacturers recommendations
- √ Indications and contraindications reviewed
- √ Manitoba Health anaphylaxis protocol in non-hospital setting near
- √ Anaphylaxis kit ready and near
- √ Telephone near in case of emergency

*After*

- √ Vaccine recipient under supervision for 15 minutes after the immunization
- √ Documentation immunization (consent form, immunization record, client's file) completed
- √ Data entry of immunization via billing Manitoba Health (doctors and medical clinics) or data entry in Panorama by Public Health completed
- √ Phone number(s) for post-immunization questions/concerns provided to client or his/her substitute decision-maker

**Immunization References for Health Care Professionals:**

Current "Canadian Immunization Guide" by the National Advisory Committee on Immunization (NACI)  
 Current "Your Child's Best Shot, A parent's guide to vaccination" by the Canadian Paediatric Society (CPS)  
 Current "Red Book, Report Committee on Infectious Diseases" by the American Academy of Pediatrics  
 Canada Communicable Disease Reports (CCDR) by Health Canada  
 Morbidity Mortality Weekly Reports (MMWR) by U.S. Centers for Disease Control and Prevention

**Immunization Web Sites for Health Care Professionals and for the public:**

Manitoba Health Public Health Branch  
<http://www.gov.mb.ca/health/publichealth/index.html>

Health Canada Division of Immunization & Respiratory Diseases  
<http://www.hc-sc.gc.ca/pphb-dgspssp/dird-dimr/index.html>

U.S. Centers for Disease Control & Prevention:  
 National Immunization Program  
<http://www.cdc.gov/nip/default.htm>

World Health Organization:  
 Vaccines, Immunization and Biologicals  
<http://www.who.int/vaccines/>