Health Canada Santé Canada

Immunization Documentation and Consent

(A separate form is to be filled out for each immunization visit)

Client's Name: (last name, first name, middle name)		
DOB: (dd/MMM/yyyy)		*Enter additional client information on page 2*

Immunization Screening Questions *Community Health Nurse to discuss with client/caregiver & document by appropriately checking:*

Date (dd/MMM/yyyy): **Provider Initials:**

	YES	NO
1. Do we need to make any corrections to your/client's name or date of birth? If so, what changes?	☐	☐
2. Have you/the client received any vaccine(s) that we do not know about?	☐	☐
3. Have you/client received any vaccine(s) in the past 4 weeks?	☐	☐
4. Have you/the client ever had a serious reaction to a vaccine? (i.e. Guillain-Barré, difficulty breathing or swallowing, rash, etc.)	☐	☐
5. Are you/the client feeling ill today? If yes, tell me about your/the child's symptoms (fever? loss of appetite? etc.)	☐	☐
6. Do you/the client have any allergies? (antibiotics, antipyretics, previous vaccines, latex rubber, adhesive band-aids, rubbing alcohol or food)	☐	☐
7. Do you/the client take any medications on a regular basis? (prescription, over-the-counter medicine, traditional or herbal/natural medicines)	☐	☐
8. Do you/the client have any health concerns that require regular visits to a health care professional? (i.e. on a transplant list, without a spleen, immunocompromised, etc.)	☐	☐
9. Have you/the client received any blood products/transfusions in the past year?	☐	☐
10. Is it possible that you/the client could be pregnant? (if applicable)	☐	☐

Client Consent for Immunization

- ○ I have read or had explained to me information about the vaccine(s) that I/my child will be receiving.
- ○ I have had the chance to ask questions, which were answered to my satisfaction.
- ○ I am aware that personal health information collected on this form may be put into a database &/or shared with another health care provider/agency, if that is required for my/my child's care.
- ○ I understand the risks and benefits associated with and consent to receive the vaccine(s).
- ○ I agree that my/my child's complete immunization history contained in the FNIHIS may be shared with the relevant Public Health Unit for the purpose of assessing my immunization history for school attendance in accordance with Regulation 645 of the Immunization of School Pupils Act.

Vaccine(s) Being Given:

1. _____
2. _____
3. _____
4. _____
5. _____

Form of Consent: ☐ Written ☐ Verbal

Relationship: ☐ Parent ☐ Client ☐ Substitute Decision-Maker

Print Name of Person Giving Consent:

Date: dd/MMM/yyyy

Signature of Person Giving Consent: x

Mandatory Nursing Actions: *Check each item when completed. If required, document in Nursing Notes below use client's chart for additional notes.* Call Immunization Support Line @ 1-866-297-3577 if needed.

Provider Initials:

☐	Anaphylaxis kit prepared & available	☐	Teach: signs & symptoms of reaction	☐	Yellow immunization card (if available)
☐	Client's immunization history reviewed	☐	Teach: management of minor side effects	☐	Next appointment scheduled (prn)
☐	Teach: benefits & risks of vaccination	☐	All nursing documentation completed	☐	15 minutes wait post-vaccination

Nursing Notes *(if required)*

☐ *Check box if additional nursing notes were added to chart.*

Provider Name (please print)	Signature + Credentials (i.e. RN)	Initials

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Client Demographic Information

* Indicates required information

Community Name: *		**Client Status:**	☐ Status ☐ Non-status
School Name:		**Band #:**	(not mandatory)
Client's Name: * (Last, First, Middle)		**Alternate Name:** (Nickname/Alias)	
DOB: * (dd/MMM/yyyy)		**Health Card #:**	(not mandatory)
Gender: *	☐ Male ☐ Female ☐ Undifferentiated/Other	**Client Phone #:**	(not mandatory)

Vaccines Given

Date Vaccine(s) Given:	(dd/MMM/yyyy)	**Cross off any vaccine rows not used.** For historical data (vaccines previously given elsewhere) enter info in rows below, check "Historical Data" box & provide date vaccine(s) given.	**Provider Initials & Time Given**

1	**Vaccine Trade Name:**	**Route:** SC: ☐ PO: ☐ IM: ☐ ID: ☐	**Site:** Lt arm: ☐ Rt arm: ☐ Lt leg: ☐ Rt leg: ☐	☐ ***High Risk Criteria Met** (if applicable - required for some publicly funded vaccines)	**Provider Initials:**	
	Lot # & Expiry:	**Dose:** _____ mL	**Series:** # ____ of ____	☐ **Historical Data Entry from:**	**Time:** _____hrs	
2	**Vaccine Trade Name:**	**Route:** SC: ☐ PO: ☐ IM: ☐ ID: ☐	**Site:** Lt arm: ☐ Rt arm: ☐ Lt leg: ☐ Rt leg: ☐	☐ ***High Risk Criteria Met** (if applicable - required for some publicly funded vaccines)	**Provider Initials:**	
	Lot # & Expiry:	**Dose:** _____ mL	**Series:** # ____ of ____	☐ **Historical Data Entry from:**	**Time:** _____hrs	
3	**Vaccine Trade Name:**	**Route:** SC: ☐ PO: ☐ IM: ☐ ID: ☐	**Site:** Lt arm: ☐ Rt arm: ☐ Lt leg: ☐ Rt leg: ☐	☐ ***High Risk Criteria Met** (if applicable - required for some publicly funded vaccines)	**Provider Initials:**	
	Lot # & Expiry:	**Dose:** _____ mL	**Series:** # ____of ____	☐ **Historical Data Entry from:**	**Time:** _____hrs	
4	**Vaccine Trade Name:**	**Route:** SC: ☐ PO: ☐ IM: ☐ ID: ☐	**Site:** Lt arm: ☐ Rt arm: ☐ Lt leg: ☐ Rt leg: ☐	☐ ***High Risk Criteria Met** (if applicable - required for some publicly funded vaccines)	**Provider Initials:**	
	Lot # & Expiry:	**Dose:** _____ mL	**Series:** # ____of ____	☐ **Historical Data Entry from:**	**Time:** _____hrs	
5	**Vaccine Trade Name:**	**Route:** SC: ☐ PO: ☐ IM: ☐ ID: ☐	**Site:** Lt arm: ☐ Rt arm: ☐ Lt leg: ☐ Rt leg: ☐	☐ ***High Risk Criteria Met** (if applicable - required for some publicly funded vaccines)	**Provider Initials:**	
	Lot # & Expiry:	**Dose:** _____ mL	**Series:** # ____of ____	☐ **Historical Data Entry from:**	**Time:** _____hrs	

Provider Name (please print)	**Signature + Credentials (i.e. RN)**	**Initials**

Cross off any of the 5 unused 'Vaccine Trade Name' boxes prior to faxing

Fax completed page 2 to : 613-952-0177