INDIGENOUS SERVICES CANADA

PROTECTED (when Completed)
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

Consent for Immunization, Collection, Use and Disclosure of Personal Information

- 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 understand the risks and benefits associated with the vaccines, and consent to receive them.
- I understand that my/my child's personal information collected will be used and disclosed to manage and record the administration of immunizations and for public health purposes as permitted or required by law.
- I agree that my/my child's personal information including immunization history may be used or disclosed to the Sioux Lookout First Nations Health Authority (SLFNHA) to better support the delivery of immunizations, develop regional and community specific immunization coverage reports, and better integrate the SLFNHA immunization repository with the (Ontario) provincial immunization repository.
- I understand that the collection, use and disclosure of my/my child's personal information is protected under the Privacy Act; that every individual has a right to access and request a correction of his/her personal information; and that I may withdraw or amend my/my child's consent in writing at any time.
- I have read the above statements, understand the content of the consent and choose to give my consent voluntarily for myself/my child.

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 and 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 page1 & 2 to: 1-807-737-2141 Sioux Lookout Zone