

COVID-19, Influenza, and Pneumococcal Immunization Consent Form

Region _____ Clinic Location _____ Date _____

SECTIONS A, B, C, D AND E COMPLETED BY:

Client Parent/Guardian Legal or appointed decision maker

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: _____ Preferred 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, describe _____		
2. Do you have any known or suspected allergies?	Yes	No
If yes, describe _____		
3. Have you ever had a serious reaction or condition following any vaccine?	Yes	No
If yes, describe _____		
4. Do you have any health conditions that require regular visits to a doctor?	Yes	No
If yes, describe _____		
5. Are you taking any medication that affects blood clotting?	Yes	No
If yes, please list _____		
6. Is your immune system suppressed due to an autoimmune condition (i.e. Rheumatoid Arthritis, Multiple Sclerosis) or disease (i.e. Leukemia) or treatment (i.e. high-dose steroids)?	Yes	No
If yes, please describe _____		
7. Have you received a dose of a COVID-19 vaccine in the past 6 months?	Yes	No
8. Have you had a confirmed COVID-19 infection in the last 6 months?	Yes	No
If yes, when? _____		

C. Reason for Immunization – Please check the first reason that applies (Check ONE box only)

1. Health-care worker 2. High risk 3. Contact of high risk 4. No known risk

Health-care workers only • indicate your primary work setting: Long-term care / PCH Community Acute care
• print your facility / office name _____

D. Informed Consent – Consult immunization provider if no signature can be obtained

Complete ONLY ONE of the following two options:

1. Consent by client (including mature minor)

I consent to receiving:

Standard-dose Influenza vaccine
High-dose Influenza vaccine (for ages 65+)
COVID-19 vaccine
Pneumococcal vaccine (Pneu-C-20)

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 read and understood the information regarding the risks and benefits of the vaccine(s) that I am consenting to, including potential common side effects of the vaccine(s). I have had the opportunity to ask questions about the vaccine(s) which were answered to my satisfaction.

2. Consent by parent/guardian or legal or appointed decision maker

I consent to the above-named person receiving:

Standard-dose Influenza vaccine
High-dose Influenza vaccine (for ages 65+)
COVID-19 vaccine
Pneumococcal vaccine (Pneu-C-20)

Name _____

Relationship _____

Phone number _____

Date _____

Signature _____

Name of client: _____ PHIN #: _____

Parents/guardian/legal or appointed decision makers should discuss the information provided for the vaccines listed above with the child, and involve the child in the decision to provide consent to the immunization(s). Although a child may be immunized with the consent of a parent/guardian/legal or appointed decision maker, a child is entitled to be informed about immunization(s). A child may provide consent to immunization(s) if the person administering the vaccine determines that the child understands the consequences of making a decision with respect to the immunization(s), including risks and benefits of the vaccine(s), possible reactions to the vaccine, and the risks associated with not being immunized. Please refer to the Informed Consent Guidelines located at:

www.manitoba.ca/health/publichealth/cdc/protocol/consentguidelines.pdf

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 or your child 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 view from 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

E. 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 (or your child). Please, check the racial or ethnic community that best describes you (or your child):

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, do you (or your child) identify as:

First Nations Métis Inuit

THE FOLLOWING SECTION TO BE COMPLETED BY IMMUNIZATION PROVIDER

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

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

Vaccine	Date Y/M/D	Lot #	Manufacturer	Dose	Route	Site	Immunizer's Signature	Data Entry
Standard-dose Influenza				0.5ml	IM	DELToid L / R		
High-dose Influenza				0.7ml	IM	DELToid L / R		
COVID-19				0.3ml or 0.5ml	IM	DELToid L / R		
Pneumococcal (Pneu-C-20)				0.5ml	IM	DELToid L / R		

Supplementary Information All entries must be signed	
Date yyyy/mm/dd	Notes:

Immunizer: [] Harminder Sandhu #34074 [] Thera Sinclair #33286 [] other: _____