

# 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 65YO PLUS ONLY!  
 COVID-19 vaccine  
 Pneumococcal vaccine (Pneu-C-20)

Date \_\_\_\_\_

Signature \_\_\_\_\_

#### 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  
 COVID-19 vaccine  
 Pneumococcal vaccine (Pneu-C-20)

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone number \_\_\_\_\_

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](http://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.

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](http://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](http://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](http://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		
Interpreter's name or ID#:	Phone:	Date: ____/____/____ (yyyy/mm/dd)

Vaccine	Date Y/M/D	Lot #	Manufacturer	Dose	Route	Site	Immunizer's Signature	Data Entry
Standard-dose Influenza		U8426BA, prefilled U8456AA multidose	Sanofi	0.5mL	IM	Deltoid L / R		
High-dose Influenza		U8461CA E:06/25	Sanofi	0.7mL	IM	Deltoid L / R		
COVID-19		L:AW3191B E05082025	Moderna Spikevax	0.5mL/0.25	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: [ ] Mariam Jarkas, 42332. [ ] Cheryl Metzler 16478 [ ] Myrna Hamer 13633 [ ] Lovepreet Rai 46167 [ ] Maarit Maenpaa 31262