Manitoba

Print Save Clear

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: _____ 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 3 months? Yes ☐ No ☐

8. Have you had a confirmed COVID-19 infection in the last 3 months? Yes ☐ No ☐

   If yes, when? _____

C. Reason for Immunization

– To be completed only in Long-Term Care facilities and hospital settings, and/or for occupational health purposes. Please check ONE box only.

1. ☐ Occupational hazard 2. ☐ Personal Care Home resident 3. ☐ High risk environment (hospital) 4. ☐ Routine (visitors) (health care worker, volunteer)

Health care workers only • indicate your primary work setting: ☐ Long-term care ☐ 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:

☐ Influenza vaccine
☐ 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:

☐ Influenza vaccine
☐ 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		
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								
Adjuvanted Influenza								
High-dose Influenza								
COVID-19								
Pneumococcal (Pneu-C-20)								

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