Manitoba

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Administrative Use Only
Reviewer:_____ Reviewer: _____
Date: _____ Date: _____

Child/Adolescent Immunization Consent Form

Consent form completed by: ☐ Client ☐ Parent/Guardian ☐ Legal or appointed decision maker

IMPORTANT: Please return this form completed and signed to the school or public health nurse by: _____/____/____ yyyy/mm/dd ☐ N/A

School: _____ City/Town: _____ Grade: _____ Classroom: _____

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):	

B. Health History of Client

1. Does your child have any allergies? ☐ Yes ☐ No
   If yes, please describe: _____
2. Has your child ever had a serious reaction or condition following any vaccine? ☐ Yes ☐ No
   If yes, please describe: _____
3. Has your child received any vaccines in the past four (4) weeks? ☐ Yes ☐ No
   If yes, please describe: _____
4. Does your child have any health conditions that require regular visits to a doctor? ☐ Yes ☐ No
   If yes, please describe: _____
5. Does your child have any conditions that can suppress their immune system (i.e., HIV, problems with spleen, organ transplant, etc.)? ☐ Yes ☐ No
   If yes, please describe: _____
6. Is your child taking any medications and/or has recently received or is receiving any medical treatment (i.e., steroids, chemotherapy, radiotherapy, immune globulin therapy etc.)? ☐ Yes ☐ No
   If yes, please list: _____
7. Is your child pregnant, and/or breastfeeding? ☐ Yes ☐ No ☐ N/A

C. The following vaccines will be provided: *(Section to be completed by the health-care provider)*

☐	DTaP-IPV-Hib	Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenza b	☐	Pneu-C-20	Pneumococcal Conjugate 20-valent
☐	HBV	Hepatitis B	☐	Rotavirus	Rotavirus
☐	HPV	Human Papillomavirus	☐	Tdap	Tetanus, Diphtheria, Pertussis
☐	Men-C-ACYW	Meningococcal Conjugate ACYW	☐	Tdap-IPV	Tetanus, Diphtheria, Pertussis, Polio
☐	MMR	Measles, Mumps, Rubella	☐	Varicella	Varicella (chickenpox)
☐	MMRV	Measles, Mumps, Rubella, Varicella (chickenpox)	☐	Other	
☐	Pneu-C-15	Pneumococcal Conjugate 15-valent	☐	Other	

D. Informed Consent

Complete ONLY ONE of the following two options

1. Consent by parent/guardian/legal or appointed decision maker – complete one of the three options:

☐ **YES** – I consent to the above-named person receiving the vaccine(s) selected in Section C

☐ **YES** – I consent to the above-named person receiving the vaccine(s) selected in Section C, except:

_____
Please indicate which vaccine(s) you do NOT consent to the above-named person receiving

☐ **NO** – **I DO NOT** consent to the above-named person receiving the vaccine(s) selected in Section C

Name: _____ Signature: _____
Date: _____ Relationship: _____
year/month/day
Phone number(s) : home/cell: _____ w: _____
Email: _____

2. Consent by client (mature minor) – complete one of the three options:

☐ **YES** – I consent to receive the vaccine(s) selected in Section C

☐ **YES** – I consent to receiving the vaccine(s) selected in Section C, except:

_____
Please indicate which vaccine(s) you do NOT consent to

☐ **NO** – **I DO NOT** consent to receiving the vaccine(s) selected in Section C

Name: _____
Signature: _____
Date: _____
year/month/day
Phone number(s) : home/cell : _____
w: _____
Email: _____

Fact sheets regarding the benefits and risks of the vaccine(s) are available at: **www.manitoba.ca/health/publichealth/cdc/div/vaccines.html.**
If you would like to receive a fact sheet or if you have any questions, call your local public health office at: _____

I have read and understood the fact sheet(s) regarding the risks and benefits of the vaccine(s) that I am consenting to, including potential common side effects of this vaccine. Some vaccines require more than one dose within the year, my consent applies to all doses of the vaccine(s) necessary to complete the series up to one year unless I withdraw my consent by contacting my local public health office at: ***www.manitoba.ca/health/publichealth/offices.html****. 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**

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(ren) 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. Racial, Ethnic or Indigenous Identity

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 your child. Please, check the racial or ethnic community that best describes 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, please check the group you identify your child to:
☐ First Nations ☐ Métis ☐ Inuit

THE FOLLOWING SECTION TO BE COMPLETED BY THE 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)

Date yyyy/mm/dd	Vaccine	Lot #	Manufacturer	Dose	Route	Site	Immunizer's Signature	Data Entry

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