



Adult-Cognitive Disabilities

2024-25 COVID-19/Seasonal Influenza/Pneumococcal Vaccine Immunization Screening and Consent Form

**This form is to be used only for persons 18 years and older who are unable to understand and/or sign for their own medical services and have a legal substitute decision-maker.

Section 1: Client Information		
Last Name		First Name
Health Services Number	Birthdate (YY/MM/DD)	Current Age
Section 2: Vaccine Screening Questions:		
1. Is this person sick or do they have a fever today?	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, describe:
2. Has this person had a <u>severe reaction (including Anaphylaxis)</u> to the Influenza vaccine, Pneumococcal vaccine, COVID-19 vaccine, ingredients of these vaccines or any other vaccine in the past?	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, describe:
3. Is this person currently seeing a doctor regarding any new neurological symptoms or problems?	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, describe:
4. Has this person developed Guillain-Barré Syndrome (GBS) within 6 weeks of receiving influenza or COVID-19 vaccine?	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, describe:
5. Has this person ever received a dose of Pneumococcal-23 or Pneumococcal C-20 vaccine? (Most people only need one dose)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, when?
6. Does this person have any bleeding disorders?	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, describe:
Section 3: Consent for Immunization:		
<p>I have read the information immunization fact sheet(s) provided to me. I understand the benefits and possible reactions for the Influenza vaccine(s), COVID-19 vaccine and/or the Pneumococcal vaccine, and the possible risks if I choose not to have this person immunized. If there is an adverse reaction to the vaccine, medical attention will be sought and the Community Health Nurse will be informed.</p> <p>I am aware that the Health Centre Nursing Staff may access immunization records from the provincial electronic immunization registry (Panorama) to determine the need for immunization. I am aware that immunizations and health related information will be documented in Panorama and may be shared with health care professionals to provide public health services, assist with diagnosis and treatment, and to control the spread of vaccine preventable diseases.</p>		
Name of substitute decision maker (please print)		
Relationship to client		Phone Number:
I consent for the person named above to be immunized with:		
Seasonal Influenza Vaccine <input type="checkbox"/> Pneumo C-20 <input type="checkbox"/> COVID-19 <input type="checkbox"/>		
Signature:		Date: YY/MM/DD
For Office Use Only:		
Provider Signature: _____		Date: _____
FLULAVAL tetra <input type="checkbox"/>	Fluzone <input type="checkbox"/>	Fluzone HD <input type="checkbox"/>
Pneumo C-20 <input type="checkbox"/>	Lot #: _____	L R
COVID-19 <input type="checkbox"/>	Lot #: _____	L R

*****You will be required to wait fifteen minutes following immunization.*****



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Section 4: Telephone consent (Health Care Provider to complete): <input type="checkbox"/> Influenza Vaccine <input type="checkbox"/> COVID-19 <input type="checkbox"/> Pneumococcal C-20 Vaccine		
Health Care Provider to obtain consent as per Chapter 3, Section 4 of the Saskatchewan Immunization Manual (SIM), including as it relates to Panorama under Section 3 above.		
Name of Person Giving Consent:		
Relationship to Client:		Phone Number:
Name of HCP (print):	HCP Signature:	Date (Y/M/D)