Adult

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

Section 1: Client Information		
Last Name	First Name	
Health Services Number	Birthdate (YY/MM/DD)	Current Age

Section 2: Vaccine Screening Questions:			
1. Are you sick today?	No ☐	Yes ☐	If yes, describe:
2. Have you had a severe reaction (including Anaphylaxis) to the Influenza vaccine, COVID-19 vaccine, Pneumococcal vaccine, ingredients of these vaccine in the past?	No ☐	Yes ☐	If yes, describe:
3. Are you currently seeing a doctor regarding any new neurological symptoms or problems?	No ☐	Yes ☐	If yes, describe:
4. Have you developed Guillain-Barré Syndrome (GBS) within 6 weeks of receiving influenza or COVID-19 vaccine?	No ☐	Yes ☐	If yes, describe:
5. Do you have any medical conditions?	No ☐	Yes ☐	If yes, describe:
6. Have you ever received a dose of Pneumococcal-23 or Pneumococcal C-20 vaccine? (Most people only need one dose)	No ☐	Yes ☐	If yes, when?

Section 3: Consent for Immunization:

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 be immunized. If there is an adverse reaction to the vaccine, medical attention will be sought and the Community Health Nurse will be informed.

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.

I consent to be immunized with:

Seasonal Influenza Vaccine ☐
COVID-19 vaccine ☐
Pneumo C-20 Vaccine ☐

Signature: **Date:** YY/MM/DD

For Office Use Only:

Provider Signature: _____ Date: _____

FLULAVAL tetra ☐	Fluzone ☐	Fluzone HD ☐	Lot #:_____	L	R
Pneumo-C 20 ☐			Lot #:_____	L	R
COVID-19 ☐			Lot #:_____	L	R

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