



Clients 6 months-17 years of age

2024-25 Seasonal Influenza and/or COVID-19 Vaccine

Immunization Screening and Consent Form

*Please note that this form is required only for clients aged 6 months to 17 years of age when a child is not accompanied by parent/guardian, for telephone consent or for mature minor consent.

Section 1: Client Information

Last Name		First Name	
Health Card Number	Birthdate (YY/MM/DD)		Current Age

Section 2: Vaccine Screening Questions: (Parent/Legal Guardian to complete)

1. Is your child sick or do they have a fever today?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	If yes, describe:
2. Has your child had a <u>severe reaction</u> (including Anaphylaxis) to the seasonal Influenza vaccine, COVID-19 vaccine or ingredients used in these vaccines in the past?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	If yes, describe:
3. Is your child currently seeing a doctor regarding any new neurological symptoms or problems?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	If yes, describe:
4. Has your child developed Guillain-Barré Syndrome (GBS) within 6 weeks of receipt of influenza or COVID-19 vaccine?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	If yes, describe:
5. Children under 9 years of age: Has your child ever been immunized with Influenza vaccine?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	

Section 3: Consent for Immunization: (Parent/Guardian to complete)

I have read the information in the Seasonal Influenza and/or COVID-19 Vaccine information fact sheet provided to me. I understand the benefits and possible reactions of the vaccines offered, and the possible risks of not being 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 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 for my child named above to be immunized with:
 Seasonal Influenza vaccine
 COVID-19 vaccine

Parent/Guardian Name	Signature	Date	Relationship to child
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Phone Number where you can be contacted:

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



Section 4: Mature Minor Consent (16-17 years if able to demonstrate capability and understanding of standard information)

I have read the Seasonal Influenza and/or COVID-19 Vaccine information fact sheet and received answers to my question(s). 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 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

Client Signature	Health Care Provider Signature	Date (YYYY/MM/DD)
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*****You will be required to wait fifteen minutes following your immunization.*****

Section 5: Telephone Consent (Health Care Provider to complete):

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 as well as per NPAG Manual Section IX Policy #9-1 .

Name of Person Giving Consent	
Relationship to Client	Phone Number
Name of Health Care Provider (print)	Health Care Provider Signature
Date (YYYY/MM/DD)	

For Office Use Only:

Provider Signature: _____ **Date:** _____

FLULAVAL tetra Fluzone Lot #: _____ L R
 COVID-19 Lot #: _____ L R