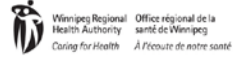


# Child Immunization Consent Form



## A. Personal information:

|         |            |     |     |        |       |           |
|---------|------------|-----|-----|--------|-------|-----------|
| Surname | Given Name | Age | Sex | School | Grade | Classroom |
|---------|------------|-----|-----|--------|-------|-----------|

|  |  |               |      |       |     |
|--|--|---------------|------|-------|-----|
|  |  | Date of Birth |      |       |     |
| 9-Digit Manitoba Health Number (PHIN#) | 6-Digit Manitoba Health Number (MHSC#) |               | Year | Month | Day |

**According to the Manitoba Routine Childhood Immunization schedule, it is time for the above person to receive the vaccine(s) checked off below:**

- |   |   |
|---|---|
| <input type="checkbox"/> DTaP-IPV-Hib Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type B<br><input type="checkbox"/> Tdap-IPV Tetanus, Diphtheria, Pertussis, Polio<br><input type="checkbox"/> Rotavirus<br><input type="checkbox"/> MMRV Measles, Mumps, Rubella, Varicella<br><input type="checkbox"/> MMR Measles, Mumps, Rubella<br><input type="checkbox"/> HB Hepatitis B (2 doses) | <input type="checkbox"/> Tdap Tetanus, Diphtheria, Pertussis<br><input type="checkbox"/> Pneu-C-13 Pneumococcal Conjugate 13 valent<br><input type="checkbox"/> Pneu-P-23 Pneumococcal Polysaccharide 23 valent<br><input type="checkbox"/> Men-C-C Meningococcal C Conjugate<br><input type="checkbox"/> HPV Human Papillomavirus (2 doses)<br><input type="checkbox"/> Flu Influenza<br><input type="checkbox"/> Other: _____ |
|---|---|

A fact sheet is attached regarding benefits and risks of the vaccine(s). Please read carefully.  
 If you did not receive a fact sheet or if you have any questions, call your local public health office : \_\_\_\_\_  
 A Public Health Nurse will provide this immunization on (date) \_\_\_\_\_

## B. Parent or legal decision-maker to complete:

1. Does your child have any allergies? No  Yes  If yes, to what? \_\_\_\_\_
2. Has your child ever had a reaction to a vaccine? No  Yes  If yes, please describe: \_\_\_\_\_
3. Does your child have any health conditions that require regular visits to a doctor? No  Yes  If yes, please describe: \_\_\_\_\_
4. Has your child ever had chickenpox? No  Yes  Year: \_\_\_\_\_
5. Has your child ever had chickenpox vaccine? No  Yes  if yes, date received: \_\_\_\_\_
6. Is your child pregnant? No  Yes  N/A

### Check only one of the following four options:

**YES - I DO Consent** to the person named above receiving the vaccine(s) identified in Section A.

OR

**YES - I DO Consent** to the person named above receiving the vaccine(s) identified in Section A except: \_\_\_\_\_

(Please indicate which vaccine(s) you do not consent for the above named person to receive)

**NO - I DO NOT Consent** to the person named above receiving the vaccine(s) identified in Section A.

OR

**NO - The person named above already received** the vaccine(s) identified in Section A.  
 Immunization received on:  
 year/month /day: \_\_\_\_\_  
 From: \_\_\_\_\_  
 (Provide name of doctor/clinic/address)

**Signature:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 Parent or legal decision-maker year/month/day

Telephone Numbers: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_  
 Comments: \_\_\_\_\_

Notice: Immunizations are recorded in the Manitoba immunization registry. If you would like more information or have any questions please speak to your health care provider. All information recorded will be protected in accordance with the Protection of Privacy provisions of The Personal Health Information Act.

## C. Section to be completed by the immunization provider:

**Verbal Consent:** The parent or legal decision-maker has been made aware of the benefits and the risks of the vaccine(s) offered to the above person and consents for the child to be immunized on the following date: \_\_\_\_\_ Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Client ID confirmed and vaccine(s) administered:

| Vaccine | Number in Series | Manufacturer | Lot # | Site | Route | Dose | Date y/m/d | Provider Signature | Panorama Entered |
|---------|------------------|--------------|-------|------|-------|------|------------|--------------------|------------------|
|         |                  |              |       |      |       |      |            |                    |                  |
|         |                  |              |       |      |       |      |            |                    |                  |
|         |                  |              |       |      |       |      |            |                    |                  |
|         |                  |              |       |      |       |      |            |                    |                  |

### Supplementary Information

| Date | Notes (include immunization refusal) | Signature |
|------|--------------------------------------|-----------|
|      |                                      |           |
|      |                                      |           |
|      |                                      |           |