PHN Check: __
Date: _____

Child Immunization Consent Form

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

A. Personal information:

Surname	Given Name	Age	Sex	School	Grade	Classroom

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

- ☐ DTaP-IPV-Hib — Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type B
- ☐ Tdap-IPV — Tetanus, Diphtheria, Pertussis, Polio
- ☐ Rotavirus
- ☐ MMRV — Measles, Mumps, Rubella, Varicella
- ☐ MMR — Measles, Mumps, Rubella
- ☐ HB — Hepatitis B (2 doses)
- ☐ Tdap — Tetanus, Diphtheria, Pertussis
- ☐ Pneu-C-13 — Pneumococcal Conjugate 13 valent
- ☐ Pneu-P-23 — Pneumococcal Polysaccharide 23 valent
- ☐ Men-C-C — Meningococcal C Conjugate
- ☐ HPV — Human Papillomavirus (2 doses)
- ☐ Flu — Influenza
- ☐ 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