Child Immunization Consent Form Manitoba

A. Personal information:

Surname | Given Name | Age | School | Grade | Classroom #

9-Digit Manitoba Health Number (PHIN#)

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, acellular Pertussis, Tetanus Polio, Haemophilus Influenza B
- ☐ DTaP-IPV Diphtheria, acellular Pertussis, Tetanus, Polio
- ☐ MMR Measles, Mumps, Rubella
- ☐ HBV Hepatitis B (3 doses)
- ☐ Tdap Tetanus, diphtheria, acellular pertussis
- ☐ Flu Influenza
- ☐ Pneu-C-13 Pneumococcal (conjugate 13 valent)
- ☐ Pneu-P-23 Pneumococcal (polysaccharide 23 valent)
- ☐ Men-C-C Meningococcal (conjugate)
- ☐ MMRV Measles, Mumps, Rubella, Varicella
- ☐ HPV Human Papillomavirus (3 doses)
- ☐ Other: ______________________
- ☐ 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 area 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? Yes☐ No☐ (If yes, please describe):______________________
2. Does your child have any health conditions that require regular visits to a doctor? Yes☐ No☐ (If yes, please describe): ______________________
3. Has your child ever had chickenpox? Yes☐ No☐ If yes, what year: _____
4. Has your child ever had chickenpox vaccine? Yes☐ No☐ Date: ______________
5. Has your child ever had a reaction to a vaccine? Yes☐ No☐ (If yes, please describe):______________________
6. Is your child pregnant? Yes☐ No☐ N/A☐ :______________________

Check one of the following four options:

☐ YES - I DO consent to the person named above receiving the vaccine(s) identified above.

OR

☐ YES - I DO consent to the person named above receiving the vaccine(s) identified above 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 above.

☐ NO - My child already received the above named vaccine(s). Immunization received on:
____
yy/mm/dd
from:______________________
(Provide name of doctor/clinic/address)

Signature: ______________________ Relationship: ______________________ Date: ______________
Parent or legal decision-maker year/month/day

Telephone number: (Home): ______________ (Work): ______________ (Cell): ______________

Comments: ______________________

Notice: Information about the immunizations you or your child(ren) receive may be recorded in the provincial immunization registry. This registry allows your health care providers to find out what immunizations you or your child have had or need to have. Information collected in the provincial immunization registry may be used to produce immunization records, or notify you or your doctor if a particular immunization has been missed. Manitoba Health, Seniors and Active Living may use the information to monitor how well different vaccines work in preventing disease. *The Personal Health Information Act* protects your information. You can have your personal health information hidden from view from health care providers. For more information, please contact your local public health office to speak with a public health nurse www.gov.mb.ca/health/publichealth/offices.html.

IMPORTANT: Please return this form completed and signed to the school or public health nurse by: ______________

Section to be completed by the immunization provider:

Name of client:______________________ PHIN #: ______________________

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: ______________
The parent or legal decision-maker has agreed to complete the Child Immunization Consent Form provided to him/her and has agreed to forward it to this immunizaton provider. Provider signature: ______________________ Date:______________

Immunization Record: The vaccine(s) identified below were administered:

Vaccine	Number in series	Manufacturer	Lot #	Site	Route	Dose	Date y/m/d	Provider signature	Data entry	Clerk's initials

TB Skin Test

Mantoux	Date planted	Lot #	Dose/Route/Site	Initial	Date read	mm of induration	Initial

Supplementary Information

Date	Notes (include immunization refusal)	Signature