

Child/Adolescent Immunization Consent Form

Consent form completed by: Client Parent/Guardian Legal or appointed decision maker

IMPORTANT: Please return this form completed and signed to the school or public health nurse by: ____/____/____ yyyy/mm/dd N/A

School: _____ City/Town: _____ Grade: _____ Classroom: _____

A. Client Information - please print

Last Name(s):		First Name(s):		Preferred Name(s):	
Address:		City/Town:		Postal Code:	
Date of Birth (yyyy/mm/dd): ____ / ____ / ____		Age:		Sex: Male Female X	
Preferred Pronoun (s) e.g. she, he, they, etc.:					
Manitoba Health Number (6 digits):			Personal Health Information Number (9 digits):		

B. Health History of Client

- Does your child have any allergies? Yes No
If yes, please describe: _____
- Has your child ever had a serious reaction or condition following any vaccine? Yes No
If yes, please describe: _____
- Does your child have any health conditions that require regular visits to a doctor? Yes No
If yes, please describe: _____
- Does your child have any conditions that can suppress their immune system (i.e., HIV infection, problems with spleen, organ transplant, etc.)? Yes No
If yes, please describe: _____
- Is your child taking any medications and/or has recently received or is receiving any medical treatment (i.e., steroids, chemotherapy, radiotherapy, immune globulin therapy etc.)? Yes No
If yes, please list: _____
- Is your child pregnant, planning to become pregnant and/or breastfeeding? Yes No N/A

C. According to the Manitoba Childhood Immunization Schedule, the above person is due for the following vaccines checked off below:

<input type="checkbox"/> DTaP-IPV-Hib	Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenza b	<input type="checkbox"/> Pneu-C-13	Pneumococcal Conjugate 13 valent
<input type="checkbox"/> HBV	Hepatitis B (2 or 3 doses)	<input type="checkbox"/> Rotavirus	Rotavirus
<input type="checkbox"/> HPV	Human Papillomavirus (2 or 3 doses)	<input type="checkbox"/> Tdap	Tetanus, Diphtheria, Pertussis
<input type="checkbox"/> Men-C-ACYW-135	Meningococcal Conjugate Quadrivalent	<input type="checkbox"/> Tdap-IPV	Tetanus, Diphtheria, Pertussis, Polio
<input type="checkbox"/> Men-C-C	Meningococcal Conjugate	<input type="checkbox"/> Varicella	Varicella (chickenpox)
<input type="checkbox"/> MMR	Measles, Mumps, Rubella	<input type="checkbox"/> Other	
<input type="checkbox"/> MMRV	Measles, Mumps, Rubella, Varicella (chickenpox)	<input type="checkbox"/> Other	

Fact sheets regarding the benefits and risks of the vaccine(s) are available at: www.manitoba.ca/health/publichealth/cdc/div/vaccines.html.

If you would like to receive a fact sheet or if you have any questions, call your local public health office at: _____

D. Informed Consent

Complete ONLY ONE of the following two options

<p>1. Consent by parent/guardian/legal or appointed decision maker – complete one of the four options:</p> <p><input type="checkbox"/> YES – I consent to the above-named person receiving the (above) vaccine(s) in Section C</p> <p><input type="checkbox"/> YES – I consent to the above-named person receiving the (above) vaccine(s) in Section C, except:</p> <p>_____</p> <p><i>Please indicate which vaccine(s) you do NOT consent for the above named person to receive</i></p> <p><input type="checkbox"/> NO – I DO NOT consent to the above-named person receiving the above vaccine(s)</p> <p><input type="checkbox"/> NO – My child already received the above named vaccine(s) on ____/____/____ from: _____ year/month/day Provide name of doctor/clinic/address</p> <p>Name: _____ Signature: _____ Date: _____ Relationship: _____ year/month/day Phone number(s) : home/cell: _____ w: _____</p>	<p>2. Consent by client (mature minor) – complete one of the three options:</p> <p><input type="checkbox"/> YES – I consent to receive the (above) vaccine(s) in Section C</p> <p><input type="checkbox"/> YES – I consent to receiving the (above) vaccine(s) in Section C, except:</p> <p>_____</p> <p><i>Please indicate which vaccine(s) you do NOT consent for</i></p> <p><input type="checkbox"/> NO – I DO NOT consent to receiving the above vaccine(s)</p> <p>Name: _____ Signature: _____ Date: _____ year/month/day Phone number(s) : home/cell : _____ w: _____</p>
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I have read and understood the factsheet(s) regarding the risks and benefits of the vaccine(s) that I am consenting to, including potential common side effects of this vaccine. Some vaccines require more than one dose within the year, my consent applies to all doses of the vaccine(s) necessary to complete the series up to one year unless I withdraw my consent by contacting my local public health office at: <https://www.gov.mb.ca/health/publichealth/offices.html>. I have had the opportunity to ask questions about the vaccine(s) which were answered to my satisfaction.

Name of client: _____ PHIN #: _____

Parents/guardian/legal or appointed decision makers should discuss the information provided for the vaccines listed above with the child, and involve the child in the decision to provide consent to the immunization(s). Although a child may be immunized with the consent of a parent/guardian/legal or appointed decision maker, a child is entitled to be informed about immunization(s). A child may provide consent to immunization(s) if the person administering the vaccine determines that the child understands the consequences of making a decision with respect to the immunization(s), including risks and benefits of the vaccine(s), possible reactions to the vaccine, and the risks associated with not being immunized. Please refer to the Informed Consent Guidelines located at: www.manitoba.ca/health/publichealth/cdc/protocol/consentguidelines.pdf

Notice: The Department of Health is authorized to collect the personal information and personal health information on this form by s. 13(1) of *The Personal Health Information Act* and s. 36(1)(b) of *The Freedom of Information and Protection of Privacy Act* because it is collected for the purpose of administering immunizations. Information about the immunizations you or your child(ren) receive will be recorded in the provincial immunization registry. Information collected in the provincial immunization registry can be used to produce immunization records, or notify you or your doctor if a particular immunization has been missed. 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.manitoba.ca/health/publichealth/offices.html

D. Racial, Ethnic or Indigenous Identity

Since May 2020, public health has been collecting information about the racial, ethnic, and Indigenous identity of individuals. The following questions will help assess vaccine coverage and determine the need for increased vaccine accessibility in different communities. We recognize that this list of racial or ethnic identifiers may not exactly match how you would describe your child. Please, check the racial or ethnic community that best describes your child.

- African Black Chinese Filipino Latin American South Asian Southeast Asian White
 North American Indigenous (First Nation, Métis, Inuit) Other Prefer not to answer

If you identified as North American Indigenous, please check the group you identify your child to:

- First Nations Métis Inuit

THE FOLLOWING SECTION TO BE COMPLETED BY THE IMMUNIZATION PROVIDER

Verbal Consent			
Date: ____/____/____ (yyyy/mm/dd)	Name:	Relationship (parent/guardian/legal or appointed decision maker/client):	Health Care Provider Signature:

Consent Using an Interpreter		
Interpreter's Name or ID#:	Phone:	Date: ____/____/____ (yyyy/mm/dd)

Date yyyy/mm/dd	Vaccine	Lot #	Manufacturer	Route	Site	Dose	Immunizer's Signature	Data Entry

Supplementary Information		
Date yyyy/mm/dd	Notes:	Signature