



Consent for Immunization

Last/Family Name		First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Ontario Health Card Number	Date of Birth		Age	School (if applicable)
	year	month		
Address		City	Postal Code	
Home Phone ()	Work Phone ()	Family Doctor and telephone number		
Screening Questions		No	Yes	If "Yes", please describe
Have you received this vaccine before?				
Have you ever had an allergic reaction to a vaccine?				
Do you have an allergy to any of the vaccine components? (see the fact sheet for the vaccines that you are here to receive)				
Do you have any serious health/immune system problems?				
Do you have a history of seizures, fainting or asthma?				
Are you on any medication?				
Have you received any blood products in the last year?				
Have you received any other vaccines in the last month?				
Are you pregnant or planning to become pregnant?				
Do you have a fever or feel sick today?				

I have read the vaccine fact sheet(s) provided and I understand the benefits, risks and possible reactions after vaccination. I have also had an opportunity to ask questions and have had them addressed to my satisfaction. I consent for the vaccine(s) to be given.

Signature: _____

Date: _____

This information is collected under the authority of the *Health Protection and Promotion Act R.S.O 1990 c.H.7., s.4* and the *Immunization of School Pupil's Act (ISPA)*. The personal health information collected on this form will be used to maintain immunization records and to monitor the use of vaccines for public health purposes. Questions regarding the collection and use of personal health information should be directed to the Office of the Privacy Officer, Simcoe Muskoka District Health Unit, 15 Sperling Drive, Barrie ON L4M 6K9, (705) 721-7520 or 1-877-721-7520.

For Nurses Use Only

Clinic Site: Barrie Midland Orillia Cookstown Gravenhurst Huntsville Alliston Other:

Date	Time	Vaccine	Lot Number	Dose	Route	Site		Nurses Signature
				mL	IM SC	Rt Lt	Arm Thigh	
				mL	IM SC	Rt Lt	Arm Thigh	
				mL	IM SC	Rt Lt	Arm Thigh	
				mL	IM SC	Rt Lt	Arm Thigh	

Nursing Interventions (sign beside each to indicate completed):

- Fact sheet (s) provided to the client or parent for review prior to immunization _____
- Reviewed the screening questions with the client _____
- Client given an opportunity to ask questions and questions were addressed _____
- After care sheet completed, reviewed and provided to the client _____

PROGRESS NOTES

Date & Time	SOAIP	S – family/individual/group perception of problem O – nurses observations A – assessment I – intervention P – plan of action

Consent ___ of ___