Immunization Screening Form

For those age 18 years and older

Personal Information

Last name: _____ (Please Print) **First name**: _____ (Please print)

Birthdate: _____ Year/Month/Day **Age:** _____ **Sask. Health Card #**: _____

Does the person being immunized have:

1. A history of severe reaction after any immunization? ☐ Yes ☐ No
2. Any severe allergies to vaccine ingredients, with the exception of eggs? ☐ Yes ☐ No
3. Do you have any medical conditions? ☐ Yes ☐ No

SHR Employee Only

SHR Employee #: _____

Other: ☐ SHR Physician ☐ Saskatchewan Cancer Agency Employee

Parklane Entered ☐

Population and Public Health Office Use Only

Seasonal Influenza Risk Factor (check one only)

	Risk #		Risk #		Risk #
☐ SHR Health Care Worker	**10**	☐ 18 – 64 years	**20**	☐ 65 years and older	**1**

Influenza Vaccine

Date: _____ YYYY _____ MM _____ DD

☐ **Dose:** 0.5 mL **Route:** IM

Lot #: _____

☐ FluLaval Tetra®

☐ Fluzone® ☐ Other _____

Site:
☐ RA
☐ LA
☐ RL
☐ LL

Clinic Location _____

Nurse's Initials: _____

Pneumococcal 23 / Tdap Vaccine

Due/eligible for: ☐ **Pneumo 23**	**Date:** _____ YYYY _____ MM _____ DD	**Lot #** _____	**Site:** ☐ RA ☐ LA	**Route:** ☐ IM ☐ SC **Dose:** 0.5 mL	**Clinic Location** _____ **Nurse Initials:** _____ **Panorama Entered:** ☐
Due for: ☐ **Tdap**	**Date:** _____ YYYY _____ MM _____ DD	**Lot #** _____	**Site:** ☐ RA ☐ LA	**Route:** ☐ IM **Dose:** 0.5 mL	

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