

Immunization Screening & Consent Form

(for mass sites only)

For those age 6 months to 17 years

Personal Information

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

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

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

I have read the information sheet for seasonal influenza. I understand the benefits of this vaccine and I am aware of the possible reactions and side effects. I understand two (2) doses, 4 weeks apart, are recommended for children under 9 years of age who are receiving their very first influenza vaccine. I understand the vaccine information provided and recorded on this document will be entered into Panorama, which is a secure provincial electronic health record system designed to store and record immunization related information.

Parent/Guardian signature _____

Date _____

Population and Public Health Office Use Only

Seasonal Influenza Risk Factor (check only one)

	Risk #		Risk #
<input type="checkbox"/> children 6 months – 8 years	22	<input type="checkbox"/> children 9 - 17 years of age	23

Influenza Vaccine

Date: _____ YYYY MM DD <input type="checkbox"/> Dose: 0.5 mL Route: IM	Lot #: _____ <input type="checkbox"/> FluLavel Tetra® <input type="checkbox"/> Fluzone®	Site: <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL	Clinic Location _____ Nurse's Initials: _____ Panorama Entered: <input type="checkbox"/>
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