PRAIRIE MOUNTAIN HEALTH

STAFF INFLUENZA/COVID-19 VACCINE CONSENT FORM

A.

Last Name	Given Names	Date of Birth	Job Classification
PHIN (9 digits)	MHSC # (6 digits)	Site/Program	Phone Number

B. HEALTH INFORMATION:

1. Are you well today? If no, describe _____ ☐ Yes ☐ No
2. Do you have any allergies? ☐ Yes ☐ No
   If yes, describe _____
3. Have you ever had a serious reaction or condition following any vaccine? ☐ Yes ☐ No
   If yes, describe _____
4. Do you have any conditions that require medication or regular visits to your doctor? ☐ Yes ☐ No
   If yes, describe _____
5. If receiving the COVID-19 vaccine, have you received a COVID-19 vaccine dose or Known SARS-CoV-2 (COVID-19) infection in the past 6 months? ☐ Yes ☐ No ☐ N/A

C. CONSENT:

I have read and understood the fact sheet provided. I have had the opportunity to ask questions about the vaccine which were answered to my satisfaction.

Notice: Information about the immunizations you receive will be recorded in your Occupational Health Annual Staff Influenza folder maintained within the PMH Human Resources Information System (HRIS). Access to this information is limited to the Occupational Health Department staff. This information may be used to monitor vaccine uptake and outbreak management. Immunization information will also be placed on the provincial immunization registry. This registry allows your health care providers to find out what immunizations you 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 health care provider 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

The following vaccines will be given - indicate with a check (√):

☐ **Influenza**

☐ **COVID-19**

Consent by Client:

Signature: _____ Date (yyyy/mmm/dd): _____

D. THE FOLLOWING SECTION IS TO BE COMPLETED BY AN IMMUNIZATION PROVIDER:

Clinic Location: _____

☐ Fact Sheet(s) reviewed ☐ Health history reviewed ☐ Questions addressed ☐ Information provided on reporting adverse events

Date y/m/d	Vaccine	Manufacturer	Lot #	Dose	Route	Site	Provider's Signature	Data Entry Initials
	Influenza							
	COVID-19							