Child Immunization Consent Form

A. Personal information:

Surname	Given Name	Age	School	Grade	Classroom

9-Digit Manitoba Health Number (PHIN#) | 6-Digit Manitoba Health Number (MHSC#) | Date of Birth: Year / Month / Day

According to the Manitoba Routine Childhood Immunization schedule, it is time for the above person to receive the vaccine(s) checked off below:

- ☐ DTaP-IPV-Hib — Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type B
- ☐ Tdap-IPV — Tetanus, Diphtheria, Pertussis, Polio
- ☐ Rotavirus
- ☐ MMRV — Measles, Mumps, Rubella, Varicella
- ☐ MMR — Measles, Mumps, Rubella
- ☐ HB — Hepatitis B (2 doses)
- ☐ Tdap — Tetanus, Diphtheria, Pertussis
- ☐ Pneu-C-13 — Pneumococcal Conjugate 13 valent
- ☐ Pneu-P-23 — Pneumococcal Polysaccharide 23 valent
- ☐ Men-C-C — Meningococcal C Conjugate
- ☐ HPV — Human Papillomavirus (2 doses)
- ☐ Flu — Influenza
- ☐ Other: _____

A fact sheet is attached regarding benefits and risks of the vaccine(s). Please read carefully.
If you did not receive a fact sheet or if you have any questions, call your local public health office: _____
A Public Health Nurse will provide this immunization on (date) _____

B. Parent or legal decision-maker to complete:

1. Does your child have any allergies? No ☐ Yes ☐ If yes, to what? _____
2. Has your child ever had a reaction to a vaccine? No ☐ Yes ☐ If yes, please describe: _____
3. Does your child have any health conditions that require regular visits to a doctor? No ☐ Yes ☐ If yes, please describe: _____
4. Has your child ever had chickenpox? No ☐ Yes ☐ Year: _____
5. Has your child ever had chickenpox vaccine? No ☐ Yes ☐ if yes, date received: _____
6. Is your child pregnant? No ☐ Yes ☐ N/A ☐

Check only one of the following four options:

☐ **YES - I DO Consent** to the person named above receiving the vaccine(s) identified in Section A.

OR

☐ **YES - I DO Consent** to the person named above receiving the vaccine(s) identified in Section A except: _____

(Please indicate which vaccine(s) you do not consent for the above named person to receive)

☐ **NO - I DO NOT Consent** to the person named above receiving the vaccine(s) identified in Section A.

OR

☐ **NO - The person named above already received** the vaccine(s) identified in Section A.
Immunization received on:
year/month /day: _____
From: _____
(Provide name of doctor/clinic/address)

Signature: _____ **Relationship:** _____ **Date:** _____
Parent or legal decision-maker — year/month/day

Telephone Numbers: (Home): _____ (Work): _____ (Cell): _____
Comments: _____

IMPORTANT: Complete & sign this form, return to School or Public Health Nurse by:

Notice: Information about shots that are given may be recorded in the Manitoba Immunization Monitoring System (MIMS) to support health care by ensuring your child's doctor or public health nurse can find out what shots he/she has had or needs to have. Information collected in MIMS may also be used by Manitoba Health to produce vaccination records or notify parents or doctors when a child has missed a particular shot. Manitoba Health may use the information to monitor how well different vaccines work in preventing disease. All information recorded in MIMS will be protected in accordance with the Protection of Privacy provisions of *The Personal Health Information Act*.

C. Section to be completed by the immunization provider:

☐ Verbal Consent: The parent or legal decision-maker has been made aware of the benefits and the risks of the vaccine(s) offered to the above person and consents for the child to be immunized on the following date: _____ Provider Signature: _____ Date: _____

Client ID confirmed and vaccine(s) administered:

Vaccine	Number in series	Manufacturer	Lot #	Site	Route	Dose	Date y/m/d	Provider signature	MIMS entry	Clerk's initials
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Supplementary Information

Date	Notes (include immunization refusal)	Signature