Occupational Health Immunization Intake Form

Date: ____________________
(YYYY/MM/DD)

Personal Information:

			MALE ◯ FEMALE ◯
Given Name	**Surname**	**Employee ID**	
9 Digit Manitoba Health Number	**6 Digit Manitoba Health Number (MHSC#)**		**Date of Birth (YYYY/MM/DD)**

HEALTH HISTORY COMPLETED BY: **CLIENT** ◯ **HEALTH CARE PROVIDER** ◯ **LEGAL DECISION-MAKER** ◯

1. Are you well today? No ◯ Yes ◯ If no Describe: ____________________
2. Do you have any allergies? No ◯ Yes ◯ If yes, please describe: ____________________
3. Do you have any health conditions that require regular visits to a doctor? No ◯ Yes ◯ If yes, please describe: ____________________
4. Are you taking any medications? No ◯ Yes ◯ List: ____________________
5. Do you have any conditions that can suppress your immune system (i.e.: HIV infection, problems with spleen, organ transplant, etc.)? No ◯ Yes ◯ If yes please describe: ____________________
6. Have you ever had a reaction to a vaccine in the past? No ◯ Yes ◯ If yes, please describe: ____________________
7. Are you pregnant or considering becoming pregnant within one month? No ◯ Yes ◯ N/A ◯

The following vaccine(s) will be given: Indicate with a check (√)

☐ **Td –** tetanus, diphtheria
☐ **Tdap** – tetanus, diphtheria, pertussis
☐ **MMR** – measles, mumps, rubella
☐ **Influenza**
☐ **Hepatitis B** (series)
☐ **Hepatitis A & B** (series)
☐ **Varicella**
☐ **TB (Tuberculosis) Skin Test**

Client's Signature:____________________Date: ____________________

Immunization Record: The vaccines identified below were administered:

Vaccine	# in Series	Manufacturer	Lot #	Dose	Route	Site	Date YYYY/MM/DD	Provider signature	PHIMS Entry
									◯
									◯
									◯
									◯

Tuberculin Skin Test

TST Step	Date Planted	Lot #	Dose/Route	Site	Initial	Date Read	Result in mm	Initial
			5 tuberculin units of PPD Tuberculin 0.1 ml intradermal					
			5 tuberculin units of PPD Tuberculin 0.1 ml intradermal					

Provider Signature	Initial	Provider Signature	Initial

If history of positive TST test:

Assess for signs & symptoms of Tuberculosis: cough, sputum, unexpected weight loss, loss of appetite, night sweats, chest pain, fever, swollen glands: No symptoms ◯ Symptoms Present ◯

Describe: ______________________________

Supplementary Information

Date	Notes (include immunization refusal)	Signature
	Provided and reviewed fact sheet(s)	
	Answered questions and concerns	
	Explained to report vaccine side effects	
	Health history completed	

Entered in to QHR	Date	Initial