Child Immunization Consent Form

Manitoba

A. Personal information:

Surname	Given Name	Age	School	Grade	Classroom #

9-Digit Manitoba Health Number (PHIN#)

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, acellular Pertussis, Tetanus, Polio, Haemophilus Influenzae B	☐ **Pneu-C-13**	Pneumococcal (conjugate 13 valent)
☐ **DTaP-IPV**	Diphtheria, acellular Pertussis, Tetanus, Polio	☐ **Pneu-P-23**	Pneumococcal (polysaccharide 23 valent)
☐ **MMR**	Measles, Mumps, Rubella	☐ **Men-C-C**	Meningococcal (conjugate)
☐ **HBV**	Hepatitis B (3 doses)	☐ **MMRV**	Measles, Mumps, Rubella, Varicella
☐ **Tdap**	Tetanus, diphtheria, acellular pertussis	☐ **HPV**	Human Papillomavirus (3 doses)
☐ **Flu**	Influenza	☐ **Other:**	
		☐ **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 area 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, please describe):_____
2. Does your child have any health conditions that require regular visits to a doctor? No ☐ Yes ☐ (If yes, please describe):
   _____
3. Has your child ever had chickenpox? No ☐ Yes ☐ Year: _____
4. Has your child ever had chickenpox vaccine? No ☐ Yes ☐ Date: _____
5. Has your child ever had a reaction to a vaccine? No ☐ Yes ☐ (If yes, please describe):_____
6. Is your child pregnant? No ☐ Yes ☐ N/A ☐ : _____

Check one of the following four options:

☐ **YES - I DO** consent to the person named above receiving the vaccine(s) identified above.

OR

☐ **YES - I DO** consent to the person named above receiving the vaccine(s) identified above 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 above.

☐ **NO** - My child already received the above named vaccine(s). Immunization received on:

_____
yy/mm/dd

from:_____
(Provide name of doctor/clinic/address)

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

Telephone number: (Home): _____ (Work): _____ (Cell): _____

Comments: _____

Notice: Information about vaccines that are given may be recorded in the Manitoba Immunization Monitoring System (MIMS) to support health care by ensuring your child's health care provider can find out what vaccines 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 health care providers when a child has missed a particular vaccine. 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.*

IMPORTANT: Please return this form completed and signed to the school or public health nurse by: _____

Section to be completed by the immunization provider:

Name of client:_____ PHIN #: _____

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: _____
The parent or legal decision-maker has agreed to complete the Child Immunization Consent Form provided to him/her and has agreed to forward it to this immunizaton provider. Provider signature: _____ Date: _____

Immunization Record: The vaccine(s) identified below were administered:

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

TB Skin Test

Mantoux	Date planted	Lot #	Dose/Route/Site	Initial	Date read	mm of induration	Initial

Supplementary Information

Date	Notes (include immunization refusal)	Signature