CONSENT
FOR IMMUNIZATION (WRITTEN)

VACCINE GIVEN: _____
DATE: _____
DOSE __ of __ (write 1 of 1 if not part of a series)

❶ CLIENT INFORMATION

Complete Sections 1, 2, and 3 (please print)

Last Name:	First Name:	Date of Birth (YYYY/MM/DD):
Address:		Telephone Number:
Emergency Contact and Relation:		Emergency Telephone Number:
Personal Health Number:	Sex: ☐ Female ☐ Male ☐ Transgender	Pregnancy Status: ☐ No ☐ Yes ☐ N/A

❷ OTHER HEALTH INFORMATION

☐ My immune system is affected by a severe disease or medication. If checked, please specify: _____

☐ I have had a serious life-threatening allergic reaction. Please specify: _____

☐ I have received another vaccine in the last 4 weeks. Please specify: _____

❸ CONSENT

☐ Client ☐ Parent ☐ Legal guardian ☐ Representative

I understand the information in the HealthLink BC File(s) for the vaccine listed below. I understand the benefits and possible reactions of the vaccine and the risk of not getting immunized. I have been informed of any medical reason why the vaccine listed below should not be given to me/my child. I have had the opportunity to ask questions that were answered to my satisfaction. I understand this consent is valid for the vaccine listed below unless the consent is cancelled.

☐ I consent to receiving/for my child to receive, the vaccine listed below.
☐ I will stay in the pharmacy for at least 15 minutes after the injection and seek medical attention if needed.
☐ I will report any adverse effects I experience to the immunizing pharmacist.
☐ I consent for the information collected on this form to be provided to my Family Physician (or Physician of my choice) and to the Health Authority for entry into my immunization record. I understand the information will be used and disclosed in accordance with the *Freedom of Information and Protection of Privacy Act* and that summary statistical information may be reported to the Ministry of Health.

Name (PRINT) _____ Phone _____

Signature _____ Date signed (YYYY/MM/DD) _____

FOR PHARMACIST USE ONLY

❹ VACCINE INFORMATION

Name of vaccine: _____ DIN: _____

Dose: _____ mL Site: LA / RA Route: IM / SC / ID / IN

Lot #: _____

Expiry date (YYYY/MM/DD): _____

LA left arm; RA right arm; IM intramuscular; SC subcutaneous; ID intradermal; IN intranasal.

Pharmacy Label

❺ PHARMACY INFORMATION

Pharmacist signature: _____ License number: _____

Date of administration (YYYY/MM/DD): _____Time of administration: _____

❻ CLIENT RESPONSE

Before: Normal Yes ☐ No ☐ _____ **15-30 mins post-administration:** Normal Yes ☐ No ☐ _____

During: Normal Yes ☐ No ☐ _____ **Other comments:** _____

Faxed to Public Health Unit: Yes ☐ No ☐ **Faxed to Physician**: Yes ☐ No ☐

Name of Public Health Unit & Fax #: _____ **Name of Physician & Fax #:** _____