Name: _____

Date of birth: _____

HCN and expiry: _____

Address: _____

_____

_____

Telephone: _____

Adult Immunization Consent Form

Request for administration of the following vaccines and/or tests (select all that apply):

☐ Influenza	☐ Pneumococcal Conjugate
☐ Haemophilus influenzae type b (Hib)	☐ Respiratory Syncytial Virus (RSV)
☐ Hepatitis A	☐ Inactivate Polio (IPV)
☐ Hepatitis B	☐ Rabies
☐ Hepatitis A & B	☐ Tetanus, diphtheria, acellular pertussis (Tdap)
☐ Human papillomavirus (HPV)	☐ Varicella
☐ Measles, mumps, rubella (MMR)	☐ COVID-19
☐ Meningococcal C-ACWY-135	☐ Tuberculin Skin Test (TST)
☐ Meningococcal B	☐ Shingles
☐ Avian Influenza (Arepanrix)	☐ Other (specify)

Screening Questions	Yes	No	Not Applicable
Do you have any allergies? (if yes, please list)	☐	☐	☐
Have you ever had an allergic reaction to a previous vaccine?	☐	☐	☐
Are you pregnant?	☐	☐	☐
Do you have any past or present medical or immunocompromising conditions?	☐	☐	☐
Have you received another vaccine within the last six-eight weeks?	☐	☐	☐
Are you well today with no fever?	☐	☐	☐

Consent

I _____ understand the information shared regarding the risks and benefits of vaccination. I consent to have the vaccines selected above administered. I also consent to allow the health care provider to share this personal health information with the custodians of health information to include in my electronic health profile.

_____ _____

Signature Date

This personal health information is being collected and used under the authority of s. 29 and s.34(a)(m) of the Personal Health Information Act and will be used for determining eligibility to receive subsequent immunizations and monitor provincial vaccine uptake. If you have concerns about the collection, use or disclosure of your personal health information, please contact the privacy office of your organization.

Name: _____

Date of birth: _____

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Address: _____

_____

_____

Telephone: _____

Adult Immunization Consent Form

For Healthcare Provider Completion (not public health or occupational health staff)

Please complete table below for vaccinations administered:

Vaccine (for example: Tdap, MMR, RSV, Shingles, etc).	Lot #	Dose	Administration Site (LA, LL, RA, RL)	Healthcare Provider Signature

This personal health information is being collected and used under the authority of s. 29 and s.34(a)(m) of the Personal Health Information Act and will be used for determining eligibility to receive subsequent immunizations and monitor provincial vaccine uptake. If you have concerns about the collection, use or disclosure of your personal health information, please contact the privacy office of your organization.