Consent form for Influenza, Pneumococcal and COVID-19 Immunizations

As per the New-Brunswick (NB) *Public Health Act*, publicly funded vaccinations must be reported to Public Health NB within 1 week of administration. If the provider does not have access to the Public Health Information System (PHIS), or Medicare billing (for Physicians and NP's), or the Drug Information System (for Pharmacy) please send this form to the Public Health data entry team by following this process:

1. **Fax the consents** to 1-833-415-1830 with a cover sheet that includes the name of the facility/immunization clinic and the total number of consents being faxed. **Please also send an email** to coviddataentry@gnb.ca to confirm the name of the facility/immunization clinic and total number of consents being faxed.
2. If faxing is not an option, contact coviddataentry@gnb.ca for proper instructions on mailing the consents.

Section 1

Personal information

Last name	First name	Medicare number	D.O.B (YYYY/MM/DD)

Home phone	Mobile phone	Email

Street address	City	Province	Postal code

Gender (*leave blank if you prefer not to indicate*)	Reason for immunization
Male ☐ Female ☐ X ☐	Adult Residential facility /Nursing Home ☐ Health Care Workers ☐

Section 2

Please review vaccine information with the person being immunized for informed consent.

	Yes	No
Are you ill today with any flu or COVID-19-like symptoms?	☐	☐
Do you have any allergies or allergy to a component of the vaccine? If yes, please specify: _____	☐	☐
Have you ever had a serious reaction (i.e., anaphylaxis) or a diagnosed condition (i.e., Guillain-Barré Syndrome) following any previous vaccine? If yes, please specify: _____	☐	☐
Do you have any diagnosed conditions or problems with your immune system?	☐	☐
Are you taking anticoagulants (blood thinners) or have a bleeding disorder?	☐	☐
Are you pregnant or planning plan to get pregnant or breastfeeding?	☐	☐

Additional information for COVID-19 vaccines:

1. What was the date of your last COVID-19 vaccine dose? _____
2. Have you had a positive test for COVID-19 in the last 6 months? If yes, indicate the date of positive test: _____
3. Have you had a condition known as Multisystem Inflammatory Syndrome? Yes ☐ No ☐
4. Have you had a condition known as myocarditis or pericarditis within 6 weeks of getting a COVID-19 vaccine? Yes ☐ No ☐

New Nouveau Brunswick

2024-03-22

Last name		First name	

Section 3

Informed consent

I confirm the following today:

- I have read the information given on the vaccine (s) being offered to me today.
- I know about and understand the risks, benefits, and common side effects of the vaccine (s).
- I have had an opportunity to discuss my questions as they relate to the vaccine (s), and were answered to my satisfaction.
- I understand that I may withdraw this consent at any time by informing the health care provider who is giving the vaccine (s) .
- I confirm that I have the legal authority to consent to this immunization.

Should you decide to provide all of the information requested on this form, it is important to know that its submission constitutes consent to the collection and disclosure of your personal information. The collection and disclosure is protected by the *Right to Information and Privacy Act* (RTIPPA) and the *Personal Health Privacy and Action Act* (PHIPAA) and all other applicable legislation, regulation or policy. If you wish to know more about your privacy rights, please consult the Government of New-Brunswick's Finance and Treasury Board.

Complete only ONE of the following two options:

Option 1: ***Consent by the parent/guardian/legal substitute decision maker***	***Option 2:*** ***Consent by the client (including mature minor)***
I hereby give consent for the individual named above to receive the following vaccine (s): ☐ Influenza High Dose *(ages 65 years and older)* ☐ Influenza Standard Dose (*ages 6 months and up*) ☐ Influenza FluMist (*only for ages 2-17*) ☐ Pneumococcal Vaccine ☐ COVID-19 Vaccine Relationship to the client (parent/guardian/legal substitute decision maker): _____	I hereby give consent to receive the following vaccine (s): ☐ Influenza High Dose *(ages 65 years and older)* ☐ Influenza Standard Dose (*ages 6 months and up*) ☐ Influenza FluMist (*only for ages 2-17*) ☐ Pneumococcal Vaccine ☐ COVID-19 Vaccine

Printed name of person giving consent/client		Signature of person giving consent/client		Date (YYYY/MM/DD)

Section 4

Vaccine administration

Name of Vaccine Given	Lot #	expiry date	Site	Route	Dosage	Date given (YYYY/MM/DD)

Immunizer's **full** printed name		Immunizer's signature		Designation