

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):

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

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

## 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

**Adult Immunization Consent Form**

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HCN and expiry: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

***For Healthcare Provider Completion***

Please complete table below for vaccinations administered:

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