



**SEASONAL INFLUENZA / PNEUMOCOCCAL-23 IMMUNIZATION CONSENT
FOR ADULTS WITH COGNITIVE DISABILITIES**

This form is to be used only for persons 18 years and older who are unable to understand and/or sign for their own medical services and have a legal substitute decision-maker.

Section 1: Client Information		
Last Name	First Name	Gender M F
Health Services Number	Birthdate (MM/DD/YY)	Personal Care Home (if applicable)
Section 2: Vaccine Screening Questions: (Substitute Decision-Maker or Physician to complete)		
1. Is this person sick today? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:		
2. Has this person had a life threatening reaction (anaphylaxis) to the seasonal Influenza vaccine or its components in the past? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe		
3. Does this person have any severe allergies? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:		
4. Has this person developed Guillain-Barré Syndrome (GBS) within 6 weeks of receiving influenza vaccine? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe		
5. Has this person ever received pneumococcal-23 vaccine? (most people only need one dose) No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, when?		
Section 3: Consent for Immunization: (Substitute Decision-Maker or Physician to complete)		
I have read the information in the immunization fact sheet(s). I am aware that the Saskatchewan Health Authority may access immunization records from the provincial electronic immunization registry (Panorama) to determine the need for immunization. I am aware that immunizations and health related information will be documented in Panorama and may be shared with health care professionals to provide public health services, assist with diagnosis and treatment, and to control the spread of vaccine preventable diseases.		
Name of Substitute Decision-Maker or Physician		
Relationship to Client	Daytime Phone Number	
I consent for the person named above to be immunized with <u>Seasonal Influenza Vaccine</u>:	I consent for the person named above to be immunized with <u>Pneumococcal-23 Vaccine</u>:	
Signature:	Date: MM/DD/YY	Signature:
		Date: MM/DD/YY
Section 4: Telephone Consent (Health Care Provider to complete): Influenza Vaccine <input type="checkbox"/> Pneumococcal-23 Vaccine <input type="checkbox"/>		
Health Care Provider to obtain consent as per Chapter 3, Section 4 of the Saskatchewan Immunization Manual (SIM), including as it relates to Panorama under Section 3 above.		
Name of Substitute Decision-Maker or Physician		
Relationship to Client	Phone Number	
Name of Health Care Provider (print)	Health Care Provider Signature	Date (MM/DD/YY)