



**Seasonal Influenza Vaccine Immunization Consent
Child not Accompanied by Parent or Guardian/Telephone Consent/Mature Minor
6 months to 17 years old**

Section 1: Client Information			
Last Name	First Name	Gender	M F
Health Services Number	Birthdate (MM/DD/YY)	Age of Child	
Section 2: Vaccine Screening Questions: (Parent/Legal Guardian to complete)			
1. Is your child sick today? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:			
2. Has your child had a life threatening reaction (anaphylaxis) to the Influenza vaccine or its components in the past? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe			
3. Does your child have any severe allergies? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:			
4. Has your child developed Guillain-Barré Syndrome (GBS) within 6 weeks of receipt of influenza vaccine? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:			
5. Has your child ever been immunized with Influenza vaccine? No <input type="checkbox"/> Yes <input type="checkbox"/>			
Section 3: Consent for Immunization: (Parent/Guardian to complete if not accompanying child)			
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.			
I consent for my child named above to be immunized with Seasonal Influenza vaccine.			
Parent/Guardian Name	Parent/Guardian Signature	Date	Phone Number
Section 4: Telephone Consent (Health Care Provider to complete):			
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 Person Giving Consent			
Relationship to Client		Phone Number	
Name of Health Care Provider (print)	Health Care Provider Signature	Date (MM/DD/YY)	
Section 5: Mature Minor Consent (13-17 years if able to demonstrate capability and understanding of standard information)			
I have read the Seasonal Influenza Vaccine information sheet and received answers to my question(s).			
I consent to be immunized with Seasonal Influenza vaccine.			
Client Signature	Health Care Provider Signature	Date (MM/DD/YY)	