COVID Immunization Entry Form

use when ImmsBC & Immunization eForm is not available

Reset Form *=required field

Optional
Place Client Label Here

INDENTIFICATION (Check-In) **Completed By** (print name)

***Appointment Date** YYYY-MM-DD	***Appointment Time**	**Confirmation Code** (ImmsBC)
***Clinic Name**	***Clinic Location** (address)	

***Legal First Name**	**Middle Name**	***Legal Last Name**	***Date of Birth** YYYY-MM-DD	***Sex** ☐M ☐F ☐Unknown (X) ☐Undifferentiated

BC PHN

Everyone receiving health care in BC must have or get a PHN, including visitors. If a client doesn't have a PHN, get them one from EMPI before submitting this form.

PHN Creation Reason

- ☐ Out of BC/Canada
- ☐ International student
- ☐ No previous service
- ☐ See Other Comments below

If PHN is Unknown 1. verify identity with government ID **Verified** ☐
2. enter last address and phone # below

Address	**City**	***Province** ☐ BC	**Country** ☐ Canada ***Postal / Zip**

Contact Method ☐ Email ☐ Text ☐ Call | **Primary Phone #** | **Email**

Indigenous Person? ☐ Yes select all that apply: ☐ First Nations ☐ Inuit ☐ Metis ☐ Unknown **Reserve Name** if applicable

Clinically Extremely Vulnerable (CEV)? ☐ Yes ☐ No ☐ Unknown **Accommodation Needs?** (e.g. translator, disability, assistance)

REASON FOR VACCINE DEFERRAL (IMMS BC **ONLY** if applicable) **Completed By** (print name)

☐ Vaccine supply issue ☐ Referred to doctor ☐ Left without seeing clinician ☐ Allergy testing required ☐ Client/parent/guardian request
☐ Immunization not given on clinical recommendation (specify)

VACCINE ADMINISTRATION **Completed By** (print name)

Consent for Series Obtained From
☐ Client ☐ Client (Mature Minor)
☐ Substitute Decision Maker/Parent/Guardian
☐ Consent Previously Obtained

☐ Client (Mature Minor - Sensitive) For a child who wants their immunization record kept confidential (not accessible to their parent/guardian). Enter the child's preferred contact # (right) and other details in Other Comments (bottom of form).

Preferred Telephone #
This # is a: ☐ Mobile Contact ☐ Primary Home ☐ Message Number ☐ Text Only

Name of Person Giving Consent
Relationship to client

Form of Consent ☐ In Person ☐ Telephone ☐ Written

***Provider First Name**	***Provider Last Name**	**Provider Designation** ☐ RN ☐ LPN ☐ NP ☐ MD ☐ Pharmacist ☐ Other (specify)

***Reason For Immunization** ☐ AL Resident ☐ AL Staff ☐ LTC Resident ☐ LTC Staff ☐ High Risk ☐ Routine Vaccine

***Date Administered** YYYY-MM-DD	***Time Administered**	**Dosage** mL	***Route** Intramuscular (IM)

Injection Site
- ☐ Arm Left Deltoid
- ☐ Arm Right Deltoid
- ☐ Other (specify):

Manufacturer and Trade Name
- ☐ **COMIRNATY** (Pfizer)
- ☐ **NUVAXOVID**
- ☐ **SPIKEVAX** (Moderna)

***Lot #**

Lot # Expiry Date

AFTER-CARE if applicable **Completed By** print name

Intervention Necessary? ☐ Yes **Intervention Comments**

Other Comments

Only enter the immunization in **ONE** system. **Entered in:** ☐ ImmsBC ☐ Immunization eForm ☐ PIR (Panorama)

Keep this document for audits. It may go on the client record. DO NOT DESTROY.