



FLU AND PNEUMOCOCCUS VACCINATION

Patient's last and first name								
Mother's last and firs	t name							
Father's last and first	name (option							
	Year N	lonth Day	Sex					
Date of birth			M	F				
Health insurance nur	nber		Year	Month				
		Expiry date						
Address (number, str								
City			Postal cod					

(Has the patient ever had a significant reaction to a vaccine or other product that required a visit to the hospital?) I. Pregnancy (If the patient is a woman, is she pregnant?) Immunizing products (Has the patient received a vaccine in the last month?) Contacts (Is the patient in close contact with a severely immunocompromised person?) or contraindications and precautions, please refer to the Inf injectable section and Inf intranasal section of the Protocole d'immunisation du Québec. ADMINISTRATION REASON (by priority order) O7 – Influenza – Resident in a CHSLD									
Capable user 14 years of age or older rea code Home phone no	GENEF	RAL INFORMATION							
Patient under 14 years of age or adult incapable of giving consent uthorized person as they so declare: (last name, first name): Mandatary									
mail address: Patient under 14 years of age or adult incapable of giving consent Email address: Email	rea code	e Home phone no	Area code Other phone no.						
Patient under 14 years of age or adult incapable of giving consent uthorized person as they so declare: (last name, first name): Mandatary					Cell		Work		
uthorized person as they so declare: (last name, first name): Mandatary	mail add	dress:							
uthorized person as they so declare: (last name, first name): Mandatary	Patient	under 14 years of age or adul	t incapable of giving consent						
Person showing a special interest in this adult				Email addre	ss:				
Person showing a special interest in this adult									
Person showing a special interest in this adult	☐ Man	datary Guardian D	Curator Public curator	Spouse (m	narried,	civil u	nion, o	r common law)	Close relative
PRE-IMMUNIZATION QUESTIONNAIRE* TO BE CHECKED BY THE VACCINATOR Health problems (Has the patient experienced any recent changes in their health? Do they have asthma? Are they experiencing severe congestion/runny nose? Are they taking ASA or medications containing it?) Immunosuppression (Is the patient taking any immunosuppressive medications? Are they immunocompromised or do they have an autoimmune disease?) Previous reactions (Has the patient ever had a significant reaction to a vaccine or other product that required a visit to the hospital?) Pregnancy (If the patient is a woman, is she pregnant?) Immunizing products (Has the patient received a vaccine in the last month?) Contacts (Is the patient in close contact with a severely immunocompromised person?) Or contraindications and precautions, please refer to the Inf injectable section and Inf intranasal section of the Protocole d'immunisation du Québec.	Porc	on chowing a chocial interact in	this adult Parental au					,	
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07 – Influenza – Resident in a CHSLD									
07 – Influenza – Resident in a CHSLD	ADMIN	ISTRATION REASON (by p	riority order)						
				10 – In	fluenz	a – H	ealthc	are worker	
TUO - INIDENZA - RESIDENTIN A REA	_								

12 – Influenza – Others reasons

09 - Influenza - Pregnant woman

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CONCENT/DECICL	ON.										
CONSENT/DECISION											
 Information on the benefits and risks of vaccination, possible reactions and what to do after being vaccinated has been given to the patient or their legal representative. The information in the sheet intended for the population targeted by the Protocole d'immunisation du Québec (PIQ) has been communicated to the patient or their legal representative. The patient will be monitored for 15 minutes after they have been vaccinated. 											
DECISION				•							
	al raproportativo										
The patient or their legal representative: Consents to vaccination against influenza Consents to vaccination against pneumococcus Refuses vaccination against influenza Refuses vaccination against pneumococcus In the case of an employee of a health institution: Consents to have this information forwarded to the health unit											
CONSENT/REFUSA	AL OBTAINED	FROM:									
Patient Mandatary Guardian Curator Public curator Close relative Spouse (married, civil union, or common law) Person showing a special interest in the person Parental authority											
INFORMATION ON	THE PROFES	SSIONAL V	WHO	OBTAINED CO	NSENT						
Full name of the profe	ssional:										
PROFESSION	Nurse	Physici	ian	Respiratory	therapist	☐ Mid	wife	Pharmac	ist		
Licence no.: Professional's signature:											
PHONE CONSENT (Complete this section only if consent is obtained by phone.)											
Name of witness:								Date	Year	Year Month Day	
Signature of the professional who obtained phone consent:								Date	Year	Month	Day
DETAILS OF VACO	INATION										
Date (year, month, day)	Hour (00:00) of vaccination	V	/accine	e Name	Batch number		Dose unit			Injection	Site
			ne qua	a drivalent quadrivalent			0.5 m or contents single-d forma	s of Intramu	scular	Right arm Left arm Right thigh Left thigh	
		Flumis	st quad	rivalent			0.1 m 0.1 m		asal [Right nostril Left nostril	
		Pneum	novax	23			0.5 m	ıl Intramu	scular	Right arm	
INFORMATION ON IMMUNIZATION PROVIDER											
Vaccinator's full name	:			Profession: Nurse	Physiciar	n Resp	iratory ther	apist	Midwife	Phari	macist
Licence no:	Vaccination s	site (LDS):									
INFORMATION ON THE PROFESSIONAL WHO ADMINISTERED THE VACCINE (Complete this section only if different from vaccinator)											
Full name of professional who administered the vaccine: Profession: Other.											
Nurse practitioner specify:											

Patient's last and first name

Record no.

Notes