Immunization Entry Form 24/25

use with ImmsBC & Digital Solution eForm

Reset Form

Use to document vaccine administration and during downtime procedures. *Indicates required field.

Optional:
Place Client Label Here

IDENTIFICATION (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**

A PHN *must* be assigned to every identified person, including non-residents or visitors, receiving a health care service in BC. **If unknown, phone AND address are required.

PHN Creation Reason

- ☐ Out of BC/Canada
- ☐ International student
- ☐ No previous service
- ☐ See comment box below

**If PHN is unknown verify identity with Government issued ID. ☐ Yes
Previous known address:

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

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 ☐ MD ☐ Pharmacist ☐ Other (specify):

Reason for Immunization

Resident In	*Essential Service Staff*	*General*
☐ Assisted Living (AL)	☐ Assisted Living (AL) ☐ Community ☐ Physician	☐ Pandemic Priority Population
☐ Long Term Care (LTC)	☐ Long Term Care (LTC) ☐ Hospital	

***Date Administered** YYYY-MM-DD	***Time Administered**	**Dosage** mL

Injection Site

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

***Route**

- ☐ Intramuscular (IM) ☐ Intranasal (IN)

COVID-19 Vaccine Products

- ☐ **Spikevax®** (Moderna)
- ☐ **Comirnaty®** (Pfizer)
- ☐ **Nuvaxovid™** (Novavax)
- ☐ **Other:** _____

Influenza Vaccine Products

- ☐ **Flumist®**
- ☐ **FluLaval® Tetra**
- ☐ **Fluzone® Quad**
- ☐ **Fluad®**
- ☐ **Afluria® Tetra**

***Lot #**

***Expiry Date**

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

Intervention Necessary? ☐ Yes **Medical Intervention Comments**

Additional Comments

Only enter the immunization into **ONE** system. **Entered into:** ☐ ImmsBC ☐ COVID-19 Immunization eForm ☐ PIR (Panorama)

This document must be kept for audit purposes. It may become part of the client record. DO NOT DESTROY.