



Immunization Entry Form 25/26

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 <i>must</i> 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
☐ AL Resident ☐ LTC Resident ☐ Student Health Care ☐ High Risk ☐ Contact (Household or Other)
☐ AL Staff ☐ LTC Staff ☐ Travel ☐ Routine Vaccine ☐ Occupational hazard

*Date Administered YYYY-MM-DD		*Time Administered		Dosage mL	
Injection Site ☐ Arm - Left Deltoid ☐ Arm - Right Deltoid ☐ Other (specify):		COVID-19 Vaccine Products ☐ Spikevax® (Moderna) ☐ Comirnaty® Adult/Adolescent (Pfizer)		Influenza Vaccine Products ☐ Flumist® ☐ Fluviral® ☐ Fluzone® ☐ Fluad®	
*Route ☐ Intramuscular (IM) ☐ Intranasal (IN)				*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.