Vaccination

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General Information

*Name: ____
Address: ____
Phone Number: ____

Manitoba Health Card

*MHSC (6 Digits): ____
*PHIN (9 Digits): ____
*Date of Birth: ____

Health Questionnaire

Family Physician: ____
Medical Allergies: ____
Medical Conditions: ____
Current Medications: ____
____
____
____
____

Do you want a review to help simplify and optimize your medications: Y/N
Have you had any adverse effects from your current medications: Y/N
Have you had a flu shot before: Y/N
Did you have any reactions to the flu shot in the past: Y/N
Do you consent to the administration of the Vaccine: Y/N

Signature: ________________________ **Date**: ______________

For Health Care Professional

Notes:

Basic Assessment
- Review Hx:
- Overall Condition/Vitals:
- Vaccine Hx:
- Condition of Admin Site:

Appropriateness:
- Indication:
- Dose:
- Allergy Status:
- Risk Factors/CI:
- Appropriate Route:
- Appropriate Vaccine:

Verification
- Drug Name:
- Indication:
- Expected Benefits:
- Expected Reactions/Side Effects:
- Post Injection Wait:
- Post Injection Follow-up:

Other Notes:

BP:

Tariff Code:

Rx:

HR:

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