Immunization Entry Form 23/24

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

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 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
☐ Assisted Living (AL)
☐ Long Term Care (LTC)

Essential Service Staff
☐ Assisted Living (AL) ☐ Community ☐ Physician
☐ Long Term Care (LTC) ☐ Hospital

General
☐ Pandemic Priority Population

*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®** XBB.1.5 (Moderna)
☐ **Cominarty®** XBB.1.5 (Pfizer)
☐ **Spikevax®** Bivalent BA.4/5 (Moderna)
☐ **Cominarty®** Bivalent BA.4/5 (Pfizer)
☐ **Nuvaxovid™** (Novavax)
☐ **Other:** _____

Influenza Vaccine Products
☐ **Flumist®**
☐ **FluLaval® Tetra**
☐ **Fluzone® Quad**
☐ **Fluad®**
☐ **Fluzone® High-Dose Quad**

***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.