IMMUNIZATION

Provincial Public Health Information System PPHIS

COVID-19 Immunization Entry Form

Optional - Place Client Label Here

*Service Delivery Location (this is the location of the immunization clinic):

Client Demographics

*Last Name (Legal):	*First Name (Legal):	Middle Name:
**BC PHN:	*Date of Birth (YYYY/MM/DD):	Email:

If BC PHN is unknown, a phone number AND address is required to align with provincial client identity standards.

*Sex:
☐ Male ☐ Undifferentiated
☐ Female ☐ Unknown

Home Phone Number:
Please confirm the most recent phone number

Country:	Province/Territory:	City/Town:

Street Address Line:

Postal Code:
This is used to identify the client health region

Address Use: ☐ Home ☐ Work ☐ Temporary ☐ No Fixed Address
Please enter city and postal code

COVID-19 Immunization History

Agent:_____
Date Administered:
_____

Volume: _____ml
Trade Name:
_____

Status:
☐ Valid ☐ Invalid

COVID-19 Consent

Informed Consent for Series Obtained From:
☐ Client
☐ Client (Mature Minor)
☐ Substitute Decision Maker

Name of Person Giving Consent:

Form of Consent:
☐ In Person ☐ Telephone
☐ Written
Please complete if obtained by Substitute Decision Maker

COVID-19 Immunization Data

*Provider Last Name	*Provider First Name:

*Reason for Immunization:
☐ Resident – Assisted Living
☐ Staff – Assisted Living
☐ Resident – Long Term Care
☐ Staff – Long Term Care
☐ Resident – Awaiting LTC or AL Placement
☐ Resident – Congregate Settings
☐ Staff – Community
☐ Staff – Hospital
☐ Staff – Pandemic Support
☐ Essential Visitor to LTC/Assisted Living
☐ Home Care Recipient
☐ Homeless or Lives in Shelter
☐ Pandemic Priority Population
☐ Paramedic/First Responder
☐ Physician

Staff Worksite/Resident's Facility:
Please enter facility if Client works or lives in Long Term Care or Assisted Living

*Agent:	*Date Administered:
*Lot Number:	Lot Number Expiry Date:

Dosage:	Dosage UOM: ml	*Site: ☐ Arm - Left Deltoid ☐ Arm - Right Deltoid	*Route: ☐ Intramuscular (IM)

Trade Name:
☐ Moderna mRNA-1273
☐ Pfizer mRNA BNT162b2
☐ Other: _____

Manufacturer:
☐ Moderna
☐ Pfizer Canada
☐ Other _____

Comment:

* indicates a required field