IMMUNIZATION

Special Considerations, Risk Factors and Deferrals

panorama

Personal Details

Last Name: _____ **First Name:** _____ **Client ID:** _____

DOB (yyyy/mm/dd): _____ **Gender:** _____ **Health Card No:** _____

Address: _____ **Phone No:** _____

_____

Special Considerations

***Organization:** _____ ***SDL:** _____

*Type[1]	*Reason for Special Consideration[2]	*Agent	*Effective From	*Source of Evidence[3]	Comments

Risk Factors

Category: Immunizations

Chronic Medical Condition - Bleeding Disorders (*)
Chronic Medical Condition - Cardiac Disease (*)
Chronic Medical Condition - CSF Leak (*)
Chronic Medical Condition - Cystic Fibrosis (*)
Chronic Medical Condition - Diabetes Mellitus (*)
Chronic Medical Condition - Liver Disease (*)
Chronic Medical Condition - Malignancies/Cancer (*)
Chronic Medical Condition - Renal Disease (*)
Chronic Medical Condition - Resp/Pulm Disease (*)
Chronic Medical Condition - Sickle Cell Disease (*)

Immunocompromised - Cochlear Implan (Candidate or Recipient) (*)
Immunocompromised - Congenital or Acquired, or Functional Asplenia (*)
Immunocompromised - Other (Specify) (*)
Immunocompromised - Transplant Candidate or Recipient - HSCT (*)
Immunocompromised - Transplant Candidate or Recipient - Islet Cell (*)
Immunocompromised - Transplant Candidate or Recipient - Solid Organ/Tissue (*)
Other - Risk Factor (Specify)
Special Population - Aboriginal (*)
Special Population - Chronic Salicylate Therapy (*)
Special Population - Low Birth Weight - under 2000g (*)
Special Population – Neonate - Born to HepB positive mom (*)
Special Population - Yukon Resident (*)

Immunizing Agent Deferrals

***Immunizing Agent:** _____

***Reason:**
☐ Client/Parent/Guardian Request ☐ No Valid Consent ☐ Non Responsive to Contact
☐ Parent Directed Scheduling ☐ Temporary medical condition ☐ Vaccine supply issues

***Effective From:** _____ **Expiry Date:** _____

[2]Reasons for Special Consideration:

[1]Type: Contraindication
- Anaphylactic Reaction to a Previous Dose of the Vaccine or Any of its Antigens
- Anaphylactic Reaction to a Vaccine Component
- Anaphylaxis due to Latex
- Family History of Congenital Immunodeficiency
- Guillain–Barre syndrome
- History of Intussusception
- Other (Specify in Comments)
- Pregnancy
- Severely Immunocompromised (For Live Vaccines)
- Uncorrected Congenital Gastrointestinal Conditions

[1]Type: Exemption
- Allergy Testing Required
- Antibodies/Antitoxin Levels Required
- Client/Parent/guardian Refusal: Religious/Philosophical
- Client Refusal
- Consultation with BCCDC Recommended
- Immunity – Lab Evidence
- Immunity – Previous Disease
- Immunity – Previously Immunized
- Immunization Not Given On Recommendation of Physician
- Medical – Clinical Decision
- Other Severe or Unusual Events (Specify in Comments)
- Parental/Guardian Refusal
- Recent Administration of Blood Product-Containing Antibodies
- Referred To Doctor

[1]Type: Precaution
- Blood coagulation disorder
- Chronic Underlying Illness
- Double dose of Hepatitis B required
- Fever > Or = 40.5 C within 48 Hrs. of Administration of Prior Dose
- History of Febrile Convulsion
- History of Vasovagal Syncope
- Immunize in Emergency Health Care Setting
- Immunize in Presence of Parent
- Immunosuppression (For Inactive Vaccines)
- Major Local Reaction To Previous Dose
- Monitor longer After Immunization
- Needle phobia
- Other (Specify in Comments)
- Recent Administration of Blood Product-Containing Antibodies
- Recent Administration of Live Virus Vaccine
- Renal Hepatitis B Formulation required

Special Considerations, Risk Factors and Deferrals

[3]**Source of Evidence:**

- Client/Parent/Guardian Report
- Health Care Provider
- Lab Report
- Legal Document
- Medical Health Officer (MHO)
- Medical Records Transfer
- Observed

IMMUNIZATION

Immunization Consent

panorama

Personal Details

Last Name: _____ **First Name:** _____ **Client ID:** _____

DOB (yyyy/mm/dd): _____ **Gender:** _____ **Health Card No:** _____

Address: _____ **Phone No:** _____

_____

Immunization Consent

***Immunizing Agent or series:** _____

***Instruction:** ☐ Grant ☐ Refuse

Refusal Reason: ☐ Client Refusal ☐ Parent/Guardian Refusal ☐ Other

Other Comment: _____

***Effective From Date:** (yyyy/mm/dd) _____ **Effective To Date:** (yyyy/mm/dd) _____

Consent Given By: ☐ Mature Minor ☐ Other ☐ Client ☐ Parent ☐ Guardian

Details: _____

Form of Consent: ☐ In Person ☐ Telephone ☐ Written

Consent Given To: ☐ Not Specified ☐ Last Name, First Name

Comments: _____

Immunization Consent

***Immunizing Agent or series:** _____

***Instruction:** ☐ Grant ☐ Refuse

Refusal Reason: ☐ Client Refusal ☐ Parent/Guardian Refusal ☐ Other

Other Comment: _____

***Effective From Date:** (yyyy/mm/dd) _____ **Effective To Date:** (yyyy/mm/dd) _____

Consent Given By: ☐ Mature Minor ☐ Other ☐ Client ☐ Parent ☐ Guardian

Details: _____

Form of Consent: ☐ In Person ☐ Telephone ☐ Written

Consent Given To: ☐ Not Specified ☐ Last Name, First Name _____

Comments: _____

IMMUNIZATION

Immunization Administration

panorama

Personal Details

Last Name: _____ **First Name:** _____ **Client ID:** _____

DOB (yyyy/mm/dd): _____ **Gender:** _____ **Health Card No:** _____

Address: _____ **Phone No:** _____

_____

Add Immunization

***Provider:** _____ ***Organization:** _____

***SDL:** _____

***Immunizing Agent:** _____ ***Date Administered:** (YYYY/mm/dd) _____

***Lot Number:** _____ **Dose Number:** _____

Dosage: _____

***Site:**
- ☐ Left Arm
- ☐ Left Dorsogluteal
- ☐ Left Leg
- ☐ Left Ventrogluteal
- ☐ Right Arm
- ☐ Right Dorsogluteal
- ☐ Right Leg
- ☐ Right Ventrogluteal
- ☐ Nasal
- ☐ Oral
- ☐ Unknown
- ☐ Wound

***Route:**
- ☐ Intradermal
- ☐ Intramuscular
- ☐ Intranasal
- ☐ Oral
- ☐ Subcutaneous
- ☐ Unknown

Revised Dose #: _____

Revised Dose Reason:
- ☐ Client/Parent/Guardian Reported
- ☐ Divided Dose in Multiple Sites
- ☐ Healthcare provider reported
- ☐ Immunization Dates/Details Not Available
- ☐ MHO Recommendation
- ☐ Other

Revised Dose Comments: _____

Comment: _____

***Immunizing Agent:** _____ ***Date Administered:** (YYYY/mm/dd) _____

***Lot Number:** _____ **Dose Number:** _____

Dosage: _____

***Site:**
- ☐ Left Arm
- ☐ Left Dorsogluteal
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Revised Dose Comments: _____

Comment: _____