Pneumococcal Polysaccharide Vaccine Immunization Record

PNEUMOVAX®23

<table>
<tr><td colspan="2">Date (YYYY/MM/DD):</td><td colspan="2">Location:</td></tr>
<tr><td colspan="4">Client Please Complete This Section</td></tr>
<tr><td colspan="2">Full Name:</td><td colspan="2">Do you identify as an Indigenous Person of Canada? (check all that apply)
□ Yes □ Prefer not to say □ First Nations □ Inuit □Métis □ Status □ Non-Status</td></tr>
<tr><td colspan="2">Address:</td><td colspan="2">Do you reside in a First Nations Community?
□ Yes □ No</td></tr>
<tr><td colspan="2">Date of Birth (YYYY/MM/DD):

Age:</td><td colspan="2">Health Card Number:</td></tr>
<tr><td>City:</td><td>Postal Code:</td><td colspan="2">Phone #:</td></tr>
<tr><td colspan="4">Nurse To Complete Below Section</td></tr>
<tr><td>□ Chart or records reviewed, client is eligible for Pneumo-P-23</td><td colspan="2">□ Consent Obtained

Consent Obtained From:_____
Relationship:_____</td><td>Health Centre Name:</td></tr>
<tr><td rowspan="2">Immunizing Agent:
□ Pneumo-P-23</td><td colspan="2">Dose: □ 0.5mL</td><td rowspan="2">Route:
□ IM (preferred)
□ Subcutaneous</td></tr>
<tr><td colspan="2">Site: □ Left Arm □ Right Arm</td></tr>
<tr><td>Lot #:</td><td colspan="3">Provider (print) and Designation (RN, LPN, NP):</td></tr>
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