

## Pneumococcal Polysaccharide Vaccine Immunization Record

### PNEUMOVAX®23

Date (YYYY/MM/DD):		Location:	
<i>Client Please Complete This Section</i>			
Full Name:		Do you identify as an Indigenous Person of Canada? (check all that apply) <input type="checkbox"/> Yes <input type="checkbox"/> Prefer not to say <input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Métis <input type="checkbox"/> Status <input type="checkbox"/> Non-Status	
Address:		Do you reside in a First Nations Community? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth (YYYY/MM/DD):		Health Card Number:	
Age:			
City:	Postal Code:	Phone #:	
<i>Nurse To Complete Below Section</i>			
<input type="checkbox"/> Chart or records reviewed, client is eligible for Pneumo-P-23	<input type="checkbox"/> Consent Obtained Consent Obtained From: _____ Relationship: _____	Health Centre Name (SDL):	
Immunizing Agent: <input type="checkbox"/> Pneumo-P-23	Dose: <input type="checkbox"/> 0.5mL	Route: <input type="checkbox"/> IM (preferred) <input type="checkbox"/> Subcutaneous	
	Site: <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm		
Lot #:	Provider (print) and Designation (RN, LPN, NP):		