COVID Immunization Entry Form

use when ImmsBC & Digital Solution eForm is not available

Optional
Place Client Label Here

*=required field

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

Everyone receiving health care in BC must have or get a PHN, including visitors. If a client doesn't have a PHN, get them one from EMPI before submitting this form.

PHN Creation Reason
- Out of BC/Canada
- International student
- No previous service
- See Other Comments below

If PHN is Unknown 1. verify identity with government ID **Verified**
2. enter last address and phone # below

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

Client (Mature Minor - Sensitive) For a child who wants their immunization record kept confidential (not accessible to their parent/guardian). Enter the child's preferred contact # (right) and other details in Other Comments (bottom of form).

Preferred Telephone #

This # is a: Mobile Contact Primary Home Message Number Text Only

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 NP MD Pharmacist Other (specify)

***Reason for Immunization**
- *Resident In* Assisted Living (AL) Long Term Care (LTC)
- *Essential Service Staff* Assisted Living (AL) Community Long Term Care (LTC) Physician Hospital
- *General* Pandemic Priority Population

***Date Administered** YYYY-MM-DD	***Time Administered**	**Dosage** mL	***Route** Intramuscular (IM)

Injection Site
- Arm Left Deltoid
- Arm Right Deltoid
- Other (specify):

Manufacturer and Trade Name
- **COMIRNATY Omicron XBB. 1.5 30mcg** (Pfizer)
- **COMIRNATY 5-11y Omicron XBB. 1.5 10mcg** (Pfizer)
- **COMIRNATY 6m-4y Omicron XBB. 1.5 3mcg** (Pfizer)
- **NUVAXOVID XBB.1.5**
- **SPIKEVAX XBB. 1.5** (Moderna)

***Lot #**

Lot # Expiry Date

AFTER-CARE if applicable
Completed By print name

Intervention Necessary? Yes **Intervention Comments**

Other Comments

Only enter the immunization in **ONE** system. **Entered in:** ImmsBC COVID-19 Immunization eForm PIR (Panorama)

Keep this document for audits. It may go on the client record. DO NOT DESTROY.