# Vaccine Administration Form for Data Entry into the Public Health Information Solution (PHIS)

As per the New-Brunswick (NB) ***Public Health Act***, publicly funded vaccinations must be reported to Public Health NB within one week of administration. If the provider **does not have access** to the Public Health Information System (PHIS), or Medicare billing (for Physicians and NP's), or the Drug Information System (for Pharmacy) please send this form to the Public Health data entry team by following this process:

1. **Fax the administration forms** to 1-833-415-1830 with a cover sheet that includes the name of the facility/immunization clinic and the total number of administration forms being faxed. **Please also send an email to coviddataentry@gnb.ca** to confirm the name of the facility/ immunization clinic and total number of administration forms being faxed.
2. If faxing is not an option, contact **coviddataentry@gnb.ca** for proper instructions on mailing the administration forms.

## Section 1

### PERSONAL INFORMATION

| Last name | First name | Medicare number | D.O.B (YYYY/MM/DD) |
|---|---|---|---|
| | | | |

| Home phone | Mobile phone | Email |
|---|---|---|
| | | |

| Street address | | City | Province | Postal Code |
|---|---|---|---|---|
| | | | | |

| Gender (leave blank if you prefer not to indicate) | Reason for immunization |
|---|---|
| ☐ Male ☐ Female ☐ X | ☐ Adult Residential facility / Nursing Home<br>☐ Health Care Workers |

## Section 2

### PERSONAL INFORMATION

| Name of Vaccine Given | Lot # | Expiry date | Site | Route | Dosage | Date given (YYYY/MM/DD) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| | | |
|---|---|---|
| **Immunizer's full printed name** | **Immunizer's signature** | **Designation** |

24-01134

New Nouveau Brunswick

# Consent Form for Respiratory Season Vaccines

**(For immunizer use only. No need to fax for data entry into Public Health Information Solution-PHIS)**

Name of client (printed) receiving vaccine(s) and date of birth: _____

| | YES | NO |
|---|---|---|
| Are you ill today with any flu or COVID-19-like symptoms? | O | O |
| Do you have any allergies or allergy to a component of the vaccine? If yes, please specify: _____ | O | O |
| Have you ever had a serious reaction (i.e., anaphylaxis) or a diagnosed condition (i.e., Guillain-Barré Syndrome) following any previous vaccine? If yes, please specify: _____ | O | O |
| Do you have any diagnosed conditions or problems with your immune system? | O | O |
| Are you taking anticoagulants (blood thinners) or have a bleeding disorder? | O | O |
| Are you pregnant or planning to get pregnant or breastfeeding? | O | O |

**Additional information for COVID-19 vaccines:**

1. What was the date of your last COVID-19 vaccine dose? _____
2. Have you had a positive test for COVID-19 in the last three months? _____ (If yes, recommend waiting three months for next dose)
3. Have you had a condition known as Multisystem Inflammatory Syndrome? O Yes O No
4. Have you had a condition known as myocarditis or pericarditis within 6 weeks of getting a COVID-19 vaccine? O Yes O No

## INFORMED CONSENT

I confirm the following today:

- I have read the information given on the vaccine(s) being offered to me today.
- I know about and understand the risks, benefits, and common side effects of the vaccine(s).
- I have had an opportunity to discuss my questions as they relate to the vaccine(s) and were answered to my satisfaction.
- I understand that I may withdraw this consent at any time by informing the health care provider who is giving the vaccine(s).
- I confirm that I have the legal authority to consent to this immunization.

Should you decide to provide all of the information requested on this form, it is important to know that its submission constitutes consent to the collection and disclosure of your personal information. The collection and disclosure is protected by the *Right to Information and Privacy Act* (**RTIPPA**) and the *Personal Health Privacy and Action Act* (**PHIPAA**) and all other applicable legislation, regulation or policy. If you wish to know more about your privacy rights, please consult the **Government of New-Brunswick's Finance and Treasury Board.**

## COMPLETE ONLY ONE OF THE FOLLOWING TWO OPTIONS:

| **Option 1:** Consent by the parent/guardian/legal substitute decision maker | | | **Option 2:** Consent by the client (including mature minor) | | |
|---|---|---|---|---|---|
| I hereby give consent for the individual named above to receive the following vaccine(s):<br>O Influenza<br>O Pneumococcal Vaccine<br>O Respiratory syncytial virus<br>O COVID-19 Vaccine<br>Relationship to the client (parent/guardian/legal substitute decision maker): _____ | | | I hereby give consent to receive the following vaccine(s):<br>O Influenza<br>O Pneumococcal Vaccine<br>O Respiratory syncytial virus<br>O COVID-19 Vaccine | | |
| Printed name of person giving consent/client | | Signature of person giving consent/client | _____<br>Client's signature: | Date (YYYY/MM/DD) | |

25-0205

New Nouveau Brunswick