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RÉGIE RÉGIONALE DE LA SANTÉ ET DES SERVICES SOCIAUX DU NUNAVIK
NUNAVIK REGIONAL BOARD OF HEALTH AND SOCIAL SERVICES

UNGAVA TULATTAVIK HEALTH CENTER
CENTRE DE SANTÉ TULATTAVIK DE L'UNGAVA

Inuulitsivik
Centre de santé et Services Sociaux Inuulitsivik
Inuulitsivik Health & Social Services Centre
Puvirnituq, Québec J0M 1P0

CTU-0286

IMMUNIZATION FORM

GENERAL INFORMATION

CAPABLE USER AGED 14 YEARS OR OLDER

Regional code | Telephone no. ❒ Cell ❒ Home | If you agree to be contact by E-mail, enter E-mail address :

USER UNDER 14 YEARS OR INCAPABLE USER AGED 18 OR OLDER

Authorized person according to declaration (first and last names) :

____

❒ Parental authority
❒ Spouse (married, civil union or common law)
❒ Substitute decision maker
❒ Person representing a particular interest for a user aged 18 or older
❒ Guardian
❒ Close relative of incapable user aged 18 or older

Regional code | Telephone no. ❒ Cell ❒ Home | If you agree to be contact by E-mail, enter E-mail address :

PREIMMUNIZATION QUESTIONNAIRE

ELEMENTS TO REVIEW	YES	NO	N/A	NOTES
1. Health problems Does the user have a health condition that requires medical follow-up ou regular medication and/or has there been a change in his/her state of health ?	❒	❒	❒	
2. Immunosuppression Is the user's immune system compromised by a disease (e.g., leukemia) or by current medication (e.g., chemotherapy) ?	❒	❒	❒	
3. Previous reactions Has the user experienced a serious allergic reaction that required emergency medical care ? **Or** has the user experienced a reaction serious enough to require medical consultation after administration of an immunizing agent ?	❒	❒	❒	
4. Bleeding disorders Does the user have a bleeding disorder requiring medical follow-up or use of anticoagulants ?	❒	❒	❒	
5. Immunizing agent or blood product Did the user receive a blood transfusion or an injection of immunoglobulins in the past 11 months ? Did the user receive a live, attenuated vaccine in the past four weeks ?	❒	❒	❒	
6. Pregnancy If the user is female, is she presently pregnant ?	❒	❒	❒	
7. If the user is a child under six months of age, did the mother, during pregnancy, take a biological agent for treatment of an autoimmune disorder (e.g., Crohn's disease, rheumatoid polyarthritis, lupus or psoriasis) ?	❒	❒	❒	
8. Precaution(s) / contraindication(s) according to the Québec immunization protocol *(PIQ)* for the immunizing agent(s) to administer.	❒	❒	❒	

Monitoring time recommended after administration : ❒ 15 minutes ❒ 30 minutes

Specify as needed : ____

CTU-0286

Name : _____

File : _____

REASON FOR ADMINISTRATION IF REQUIRED

INFLUENZA	❒ Resident in CHSLD ❒ Resident in elders' home ❒ Pregnant woman ❒ Health worker ❒ Chronic disease ❒ Other	**DTaP**	❒ Pregnant woman (whooping cough) ❒ Other	**COVID-19**	❒ Resident in CHSLD ❒ Resident in elders' home ❒ Pregnant woman ❒ Health worker ❒ Chronic disease ❒ Other	**MPOX**	❒ Pre-exposure – immunosuppressed ❒ Pre-exposure – not immunosuppressed ❒ Post-exposure – immunosuppressed ❒ Post-exposure – not immunosuppressed ❒ Other
		ZONA	❒ Immunosuppressed ❒ Other				
		RSV (Adults)	❒ Resident in CHSLD ❒ Resident in elders' home ❒ Other				

INFORMATION ON THE QUALIFIED PROFESSIONAL WHO REVIEWED PREIMMUNIZATION QUESTIONNAIRE

❒ Nurse ❒ Physician ❒ Inhalation therapist ❒ Midwife ❒ Pharmacist

Name :	Signature :	License no. :	Year	Month	Day

CONSENT

❒ The information on the disease(s) and on the immuzing agent(s), including possible reactions and the course of action after administration of the agents, were given to the user or his/her legal representative.

❒ Consent to administration of the following immunizing agent(s) after review of by the qualified professional :

_____

❒ Refusal of the following immunizing agent(s) :

❒ Not applicable

CONSENT / REFUSAL OBTAINED FROM :

❒ User ❒ Spouse (married, civil union or common law) ❒ Substitute decision maker

❒ Guardian ❒ Person representing a particular interest for a user aged 18 or older

❒ Parental authority ❒ Close relative of incapable user aged 18 or older

HEALTH BUREAU :

Administration of the immunizing agent(s) on recommendation of health bureau :

❒ I hereby consent to having my information sent to the health bureau.

INFORMATION ON QUALIFIED PROFESSIONAL WHO OBTAINED CONSENT :

❒ Nurse ❒ Physician ❒ Inhalation therapist ❒ Midwife ❒ Pharmacist

Name :	Signature :	License no. :	Year	Month	Day

Name of witness if consent obtained by telephone : _____

DETAILS ON IMMUNIZING AGENTS ADMINISTERED

Date	Time	Name of immunizing agent	Lot no.	Quantity/ Unit	Route of administration					Site of administration					Initials
					Intra muscular	Sub cutaneus	Oral	Intra nasal	Intra dermal	Left arm	Right arm	Left thigh	Right thigh	Other	
					❒	❒	❒	❒	❒	❒	❒	❒	❒		
					❒	❒	❒	❒	❒	❒	❒	❒	❒		
					❒	❒	❒	❒	❒	❒	❒	❒	❒		
					❒	❒	❒	❒	❒	❒	❒	❒	❒		
					❒	❒	❒	❒	❒	❒	❒	❒	❒		

LOCATION OF SERVICES PROVIDED : ❒ Entered in SI-PMI

INFORMATION ON INTERVENER WHO ADMINISTERED THE IMMUNIZING AGENT(S) :

Name :	Initials :	Signature :	Profession (specify) :	License no. :
Name :	Initials :	Signature :	Profession (specify) :	License no. :