

| CLIENT INFO   |           |                    |                   |  |
|---|-----------|--------------------|-------------------|--|
| LAST NAME   |           | FIRST NAME         |                   |  |
| DOB<br>YYYY/MM/DD   | AGE       | HEALTH CARD NUMBER | PHONE NUMBER      |  |
| HOME ADDRESS  |           | CITY               | POSTAL CODE       |  |
| CLIENT HEALTH HISTORY   |           |                    |                   |  |
| Please answer the following health history questions. A nurse will review any "yes" responses.  |           |                    |                   |  |
| 1. Are you feeling ill today?   |           | YES                | NO                |  |
| 2. Have you ever received an RSV vaccine in the past?   |           | YES                | NO                |  |
| 3. Have you ever had a serious reaction to a vaccine in the past?   |           | YES                | NO                |  |
| 4. Do you have any allergies?<br>*If client answers YES, refer to product monograph for list of ingredients.  |           | YES                | NO                |  |
| 5. Do you have a history of fainting?   |           | YES                | NO                |  |
| 6. Have you had a solid-organ or stem cell transplant in the past 3-6 months?   |           | YES                | NO                |  |
| CONSENT FOR IMMUNIZATION  |           |                    |                   |  |
| I have read (or had explained to me) and I understand the RSV Vaccine Information Sheet. I have had the opportunity to ask questions and to have them answered to my satisfaction. I hereby consent to having the RSV vaccine injection given to me by the Nurse of the Renfrew County and District Health Unit.  |           |                    |                   |  |
| If you are signing for someone other than yourself, indicate your relationship to that person:  |           |                    | RELATION          |  |
| PRINTED NAME  | SIGNATURE |                    | DATE (YYYY/MM/DD) |  |
| <small>Personal information contained on this form is collected under the authority of one or more of the following (as amended): the Health Protection and Promotion Act, R.S.O. 1990; the Immunization of School Pupils Act, R.S.O. 1990; the Regulated Health Professions Act, 1991, S.O. 1991; and is in compliance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 and the Personal Health Information Protection Act, 2004, S.O. 2004. This information is used to ensure that all appropriate personal care and public health services are provided, and that necessary statistics are kept. Questions about this collection should be directed to the Program Manager at the Renfrew County and District Health Unit, 141 Lake St, Pembroke, ON K8A 5L8, 613-732-3629.</small> |           |                    |                   |  |



**FOR CLINIC USE ONLY**

☐ I have assessed the client's age.

**CLIENT AGE**

**INITIALS**

**≥ 60 years ONLY**

| VACCINE             | DOSE  | SITE                                   | ROUTE | LOT # / EXPIRY | DATE & TIME | GIVEN BY |
|---------------------|-------|--|-------|----------------|-------------|----------|
| AREXVY<br>(GSK)     | 0.5mL | <b>Left</b> OR <b>Right</b><br>Deltoid | IM    |                | YYYY/MM/DD  |          |
| ABRYSVO<br>(Pfizer) | 0.5mL | <b>Left</b> OR <b>Right</b><br>Deltoid | IM    |                | YYYY/MM/DD  |          |

☐ Entered in Panorama