Tsleil-Waututh Nation

Cećəwət leləm "Helping House"

2020-2021 Annual Influenza Immunization Record

<table>
<tr><td colspan="2">Date (YYYY/MM/DD): 2020/11/24</td><td colspan="2">Tsleil-Waututh Nation Elders Room</td></tr>
<tr><td colspan="4">☐ No cold, flu or COVID-19-like symptoms, even mild ones, no exposure to known COVID-19 case, no international travel within last 14 days.</td></tr>
<tr><td colspan="4">Client Please Complete This Section</td></tr>
<tr><td colspan="2">Full Name:</td><td colspan="2" rowspan="3">Do you identify as an Indigenous Person of Canada? (check all that apply)
☐ Yes ☐ No ☐ Prefer not to say
☐ First Nations ☐ Inuit ☐Métis ☐ N/A
☐ Status ☐ Non-Status ☐ N/A</td></tr>
<tr><td colspan="2">Address</td></tr>
<tr><td colspan="2" rowspan="2">Street:</td></tr>
<tr><td colspan="2">Do you reside in a First Nations Community?
☐ Yes ☐ No</td></tr>
<tr><td colspan="2">City:</td><td colspan="2">Health Card Number:</td></tr>
<tr><td colspan="2">Postal Code</td><td colspan="2">Date of Birth (YYYY/MM/DD):</td></tr>
<tr><td colspan="2">Phone #:</td><td colspan="2">Age:</td></tr>
<tr><td colspan="4">Please indicate if you have (or have ever had) any of the below conditions: We ask for this information to help your Nurse to determine if you are eligible for other vaccines or medical services.</td></tr>
<tr><td colspan="2">☐ Arthritis
☐ Asthma
☐ Cancer
☐ Heart Disease
☐ COPD (Chronic obstructive pulmonary disease)
☐ Congestive Heart Failure (CHF)
☐ Dementia
☐ Diabetes
Allergies (please list):</td><td colspan="2">☐ Depression
☐ Acid Reflux
☐ Hepatitis B or C
☐ HIV
☐ High blood pressure (hypertension)
☐ Osteoporosis
☐ Currently pregnant
☐ Stroke /TIA (transient ischemic attack)
☐ Blood clots
☐ Heart attack
☐ Other chronic condition:</td></tr>
<tr><td colspan="4">Nurse To Complete Below Section</td></tr>
<tr><td rowspan="2">Immunizing Agent:
☐ FluLaval Quadrivalent
☐ Flumist Quadrivalent
☐ Agriflu
☐ Fluviral
☐ Fluad
☐ Fluzone High-Dose</td><td colspan="2">Lot #:</td><td rowspan="4">Consent Obtained ☐

From ________________

Relationship ___________

Notes:

Administered by:

Sibylle Tinsel, RN</td></tr>
<tr><td colspan="2">Dose/Route/Site:
☐ 0.5mL IM
☐ Deltoid Left ☐ Deltoid Right
☐ Vast. Lat. Left ☐ Vast. Lat. Right
☐ 0.2mL IN
☐ 2nd dose required? Date:_______</td></tr>
<tr><td>Immunizing Agent:
☐ Pneumo-P-23</td><td colspan="2">Lot #:</td></tr>
<tr><td>☐ Chart or records reviewed, client is eligible for Pneumo-P-23</td><td colspan="2">Dose/Route/Site:
☐ 0.5mL ☐ IM (preferred) ☐ SubC.
☐ Left Arm ☐ Right Arm</td></tr>
</table>