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

PRE-VACCINATION EVALUATION FORM

Newborns zero to six weeks

FILE #: ____________

LAST NAME: ___________________________________

FIRST NAME: ________________________________

DOB: _____/_____/_____
yyyy / mm / dd

SEX: ☐ M ☐ F

MOTHER: __________________________________

FATHER: __________________________________

CLSC: __________________________________

ADDRESSOGRAPH

Pre-vaccination evaluation	
1. According to the parent(s), does the child have a known immune-system problem, inherited from his biological parents?	Yes ☐ No ☐
2. According to the parent(s), is there someone with an inherited immune-system problem, identified at birth, among the child's immediate biological family (brother, sister) or among his or her biological cousins, nephews or nieces	Yes ☐ No ☐
3. Is there absence of an HIV serum test performed on the biological mother during the pregnancy or on the child?	Yes ☐ No ☐
4. For a child under the age of six months, did the mother take biological agents during the pregnancy (e.g., infliximab, étanercept)?	Yes ☐ No ☐
5. Is the child presently being investigated for a TB contact?	Yes ☐ No ☐
6. Is the child presently taking anti-tuberculosis medication?	Yes ☐ No ☐
7. Does the child have widespread dermatosis?	Yes ☐ No ☐
8. Does the child presently have an acute, moderate or serious disease with or without fever?	Yes ☐ No ☐

Note: If you replied **YES** to any of the above questions, consult the *PIQ*, (Section/Vaccins/Tuberculose/BCG) or the table for administering the BCG vaccine to children targeted for vaccination, or consult the nurse responsible for immunization at the IHC or at the RDPH to determine whether or not the vaccine can be offered.

MID WIFE SIGNATURE: ________________________ DATE: _____/_____/_____
yyyy/ mm / dd

NURSE SIGNATURE: ________________________ DATE: _____/_____/_____
yyyy/ mm / dd

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

BCG Vaccination Form

FILE #: ____________

LAST NAME: ____________________________________

FIRST NAME: _________________________________

DOB: _____/_____/_____

yyyy / mm / dd

SEX: ☐ M ☐ F

MOTHER: ___________________________________

FATHER: ___________________________________

CLSC: _________________________________

ADDRESSOGRAPH

☐ Vaccination indicated

☐ Vaccination contraindicated: enter the number of the question corresponding to the contraindication: ___________________

☐ Parental refusal

☐ Postponed: reason: ____________________________

Consent to vaccination obtained from parent? Yes ☐ No ☐
Parents' last and first names: ___________________________________

Vaccine: ☐ freeze-dried BCG with glutamate (Japan BCG Laboratory)

lot #: _______________ expiry date: _______________

DOSE: ☐ 0,05 mL ID

INJECTION SITE: ☐ left deltoid ☐ right deltoid

INJECTION DATE: ______/______/______ TIME: ____:____
yyyy/ mm / dd

NURSE'S SIGNATURE: ___________________________________