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

CTU-0134

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FORM FOR BCG VACCINATION

A. REVIEW OF FILE BEFORE MEETING WITH PATIENT

CONTRAINDICATIONS FOR VACCINATION		Yes	No
1.	According to the parent(s), in the child's immediate biological family (brothers, sisters, cousins, nephews, nieces), is there someone afflicted with an immune problem acquired at birth?		
2.	Is the biological mother HIV-positive?* Date of HIV serology performed during pregnancy for the child concerned : _______________ (yyyy/mm/dd) * If the mother refused the HIV test during the pregnancy concerned, is the child HIV-positive? If unknown, perform the HIV serology on the mother or child and wait for the result.		
3.	According to the parent(s), does the child have an immune problem inherited from his or her biological parents?		
4.	Does the child have a previous significant TST result?* *For the definition of significant TST, refer to the *Decision-making algorithm – BCG vaccination*.		
5.	Did the child receive a positive result for the SCID test? Date of test : ________________________ Result : ________________________		
SPECIFIC PRECAUTION		**Yes**	**No**
6.	For a child under six months, did the mother take biological agents during the pregnancy, such as TNFα inhibitors (in case of doubt, consult the pharmacist)?		

If you replied **YES to one of questions 1,2,3,4 or 5**, refer to the attending physician for further PRN assessment.
If the contraindication is confirmed, enter in the file and immunization registry.
If you replied **YES to question 6**, refer to the attending physician.

EXPOSURE OR RISK FACTORS FOR EXPOSURE TO TUBERCULOSIS		Yes	No
7.	Is the child presently taking medication for tuberculosis?		
8.	Is the child presently being investigated as the contact of a case of active TB or has he or she been identified as such?		

If you replied **YES to one of questions 7 or 8**, refer to the nurse responsible for TB monitoring.

INDICATION FOR PREVACCINATION TST		Yes	No
9.	Does the infant aged ≥ two months and < six months reside in one of the communities targeted by Public Health?* *For the list of the communities targeted by Public Health, refer to the *Decision-making algorithm – BCG vaccination*.		
10.	Is the infant aged ≥ six months and < 24 months?		
11.	According to the *Decision-making algorithm – BCG vaccination*, is a prevaccination TST indicated?		

If you replied **YES to one of questions 9 or 10**, refer to the *Decision-making algorithm – BCG vaccination*, available in the vaccination tool kit, for the specific recommendations formulated by the Department of Public Health.
If you replied **YES to question 11**, fill out the TST section of the present form.

Midwife's or nurse's name: ____ License no. : ______________
Midwife's or nurse's signature: ____ Date : ______________

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Nom, prénom : _____

Dossier : _____

B. FILL OUT IN THE PATIENT'S PRESENCE

TST

Child's parent or legal representative: ❒ Consented to TST ❒ Refused TST

Reason for refusal, if applicable : _____

TST performed on : _____ (yyyy/mm/dd)

Time : _____

Lot no. : _____

Site : _____

Nurse's name : _____

TST read on : _____ (yyyy/mm/dd)

Time : _____

TST result : _____ mm

Nurse's name : _____

Interpretation of result : ❒ Significant ❒ Insignificant

❒ Entered in immunization registry (SI-PMI) ❒ Entered in vaccination history

PREVACCINATION ASSESSMENT	Yes	No
12. Does the child presently have a moderate or serious acute illness with or without fever?		
13. Does the child presently have a disseminated skin affliction?		
14. Has the child ever had a significant or allergic (anaphylactic) reaction after administration of a vaccine?		
15. Did the child receive a live vaccine, excluding the oral rotavirus vaccine, in the last four weeks?		

If you replied **YES to one of questions 12, 13, 14 or 15**, refer to the *PIQ* or consult the nurse in charge of immunization at the IHC/UTHC or at the DPH to determine whether or not the vaccine can be administered.

CONSENT TO VACCINATION

Is vaccination : ❒ Indicated ❒ Contraidicated

If contraindicated, enter the number of the question corresponding to the contraindication : _____

The child's parent or legal representative :

❒ Consented to the child's vaccination with BCG ❒ Refused the child's vaccination with BCG

Reason for refusal, if applicable : _____ Consent/refusal given by : ❒ Mother ❒ Father ❒ Tutor

Reason for postponing vaccination, if applicable : _____ New date of vaccination, if known : _____ (yyyy/mm/dd)

DETAILS OF ADMINISTERED VACCINE

Date and time	Child's age	Name of vaccine	Lot no.	Expiry date	Dose	Site
(yyyy/mm/dd) (hh :mm)		❒ BCG - Japan		(yyy/mm/dd)	❒ 0,05 ml ID (age < 12 months) ❒ 0,1 ml ID (age ≥ 12 months)	❒ Left arm ❒ right arm

❒ Entered in immunization registry (SI-PMI) ❒ Entered in vaccination history

Vaccinator's name : _____ Lisence no. : _____

Vaccination site (LDS): _____ Vaccinator's signature : _____ Date : _____