**Approval for Immunization of Pediatric (those under 18 years of age) Oncology and HSCT Clients who have Completed Treatment**

To be completed by the oncologist or nurse practitioner at the oncology clinic and sent to Public Health Nurse.

<table>
<thead>
<tr>
<th>Date:</th>
<th>Treatment Completion Date:</th>
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<tbody>
<tr>
<td>YYYY/MM/DD</td>
<td>YYYY/MM/DD</td>
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</table>

**CLIENT INFORMATION**

<table>
<thead>
<tr>
<th>Name:</th>
<th>PHN:</th>
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<td>First</td>
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**Pediatric Oncology Patient who has Completed Treatment, Including Autologous HSCT**

This is to confirm that the above named patient may commence vaccination with:

- [ ] Inactivated Influenza Vaccine  
  Effective Date (YYYY/MM/DD):

- [ ] All Other Inactivated Vaccines  
  Effective Date (YYYY/MM/DD):

- [ ] Live Vaccines  
  Please Complete the LAIV, MMR and Varicella Referral Forms

- [ ] PPV23 and meningococcal quadrivalent conjugate vaccines are indicated due to splenic dysfunction

**OR**

**Allogeneic HSCT Recipient**

- [ ] Inactivated Influenza Vaccine  
  Effective Date: (YYYY/MM/DD)

- [ ] Provide Inactivated Vaccines per Table 2: Worksheet for Immunization of Pediatric Allogeneic HSCT Recipients  
  Effective Date: (YYYY/MM/DD)

- [ ] Live Vaccines  
  Please Complete the MMR and Varicella Referral Forms

**Name of Health Care Provider:**

**Signature:**

For clients receiving treatment at BC Children’s Hospital, the record of immunizations given by the public health nurse or family doctor will be sent to the attention of the Long Term Care Follow-up Nurse, Oncology, Hematology and BMT Clinic, BC Children’s Hospital, Fax: 604-875-3414.