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.

Date:		Treatment Completion Date:	
	YYYY/MM/DD		*YYYY/MM/DD*
CLIENT INFORMATION			
Name:			
	Last	*First*	
DOB:		PHN:	
	YYYY/MM/DD		

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.