Patient Consent for COVID-19 Vaccination

The vaccine may not be appropriate for all ages. Ask your pharmacist for age restrictions.

Name:	Gender:	Provincial Health Number:
Date of Birth (MM/DD/YYYY):	Age:	Patient Phone:
Address:		Email:
Emergency Contact Name:	Relationship to Patient:	Contact Phone:
Family Physician Name:	Physician Phone:	

Injection Screening Questionnaire	**Yes**	**No**
Do you have **symptoms of COVID-19?** (e.g. Fever, new onset of cough or worsening of chronic cough, shortness of breath, difficulty breathing, sore throat, difficulty swallowing, decrease or loss of smell or taste, chills, headaches, unexplained tiredness/ malaise/ muscle aches, nausea, vomiting, diarrhea or abdominal pain, pink eye or runny nose or nasal congestion without other known cause)		
In the past 14 days, did you return from travel outside of Canada or have you been in close contact with someone confirmed as having COVID-19?		
Are you **immunosuppressed** due to disease or treatment, or do you have an **autoimmune disorder**?		
Are you or could you be **pregnant**?		
Are you **nursing / breastfeeding?**		
Do you have any **severe allergies** such as anaphylaxis to any medication(s), vaccine(s) or food(s) or from an unknown cause? If yes, please elaborate on your allergies and state if you have been seen by an allergy specialist_____		
Are you **allergic to polyethylene glycol or polysorbate or tromethamine**? It can be found in some products such as cosmetics, skin care products, laxatives,cough syrups, bowel preparation products for colonoscopy, and some foods and drinks		
Do you have any **medical conditions** that require regular visits to a doctor?		
Do you have a serious allergy to **latex** or **natural rubber**?		
Do you have a **bleeding disorder** or are taking **blood thinners?** (e.g. Warfarin, Aspirin)		
Have you been hospitalized because of a COVID-19 infection? If yes, were you treated with convalescent plasma or monoclonal antibody?		
Have you ever **fainted** after a vaccination or medical procedure?		
Have you received any other vaccines (not a COVID-19 vaccine) in the past 14 days?		
Have you received any previous COVID-19 vaccine? If yes, please specify: - The date and name of the COVID-19 vaccine: _____ - Any side effects after the first dose: _____		

Consent Given By Patient/Legal Decision Maker

I, the undersigned patient/legal decision maker, have read or had explained to me information about the vaccine as outlined on the vaccine monograph and in the applicable provincial fact sheet(s) regarding the risk and benefits of this vaccine. I have had the chance to ask questions and answers were given to my satisfaction. I understand the risks and benefits of receiving the vaccine. After getting the vaccine, I agree to wait in the clinic / pharmacy for 15 minutes (or the time recommended by the pharmacist). In the event of anaphylaxis, I, my agent, and/or EMS paramedics will receive a copy of this form. I understand the information contained on this form, may be disclosed to public health authorities or your health care professionals and to other parties for the purpose of adverse event and drug safety reporting, as well as other purposes as authorized and required by law. I further understand that the information will be used for outreach, including second dose reminders, as well as potential subsequent immunization campaigns for flu or a booster COVID-19 immunization campaign.

☐ I consent to receiving the COVID-19 vaccine Signature:	☐ I consent to the above named person receiving the COVID-19 vaccine Name: Phone number: Relationship: Signature:	☐ **Verbal consent** provided

Pharmacy Use Only

☐ **COVID-19 Pfizer BioNTech Vaccine** 0.3mL IM	☐ **COVID-19 AstraZeneca Vaccine** 0.5mL IM	☐ **COVID-19 Covishield Vaccine** 0.5mL IM	☐ **COVID-19 Moderna Vaccine** 0.5mL IM
☐ **COVID-19 Johnson & Johnson Vaccine** 0.5mL IM	☐ **Other:**		
Time of Immunization:	Lot#:	Expiry Date (MM/YYYY):	Site of administration: ☐ left arm ☐ right arm

Additional Notes (including emergency measures taken or patient follow-up):

PHARMACIST'S DECLARATION: I confirm that I have communicated the risks and benefits associated with the vaccine. I have reviewed the patient record and find that the vaccine should be given to the patient. I have verified that patient meets the provincial eligibility criteria for COVID-19 vaccine. I confirm that the patient meets the age requirement for the vaccine. I confirm that the patient has been informed of the interval between doses.

Immunizer Name and Signature:	License #:	Date:

MB ONLY	**Reason for Immunization** Please check the first reason that applies (Check ONLY the first box that applies)	☐ HCP (includes all settings) ☐ Personal care home resident ☐ Other congregate living (includes residents, non-health care staff, visitors, volunteers) ☐ Community with disproportionate disease impact ☐ Routine (age)	
NS ONLY	Patient condition before:	Response during:	Response immediately after: