wholehealth+ pharmacy partners

COVID-19 Vaccine Screening & Consent Form

Last Name	First Name	Identification (e.g., health card #)	
Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ Prefer not to answer ☐ Other:		Primary Care Clinician:	
Home Phone	Mobile Phone	Email Address	
Street Address	City	Province	Postal Code
Patient Date of Birth ___/____/____ (month, day, year) Age:	Have you completed a primary COVID-19 vaccine series? ☐ Yes ☐ No Date of most recent dose: ___________		

Please answer all the questions below:	
Have you been diagnosed with myocarditis or pericarditis following a previous dose of an mRNA COVID-19 vaccine? The next dose in the mRNA vaccine series should be deferred in clients who experience myocarditis or pericarditis following a previous dose of the mRNA COVID-19 vaccine.	☐ Yes ☐ No
Have you ever had myocarditis or pericarditis before?	☐ Yes ☐ No
Do you have (or have you recently had) any shortness of breath or chest pain?	☐ Yes ☐ No
Have you had a previous COVID-19 infection within the past 6 months? *Previous infection is defined as (i) a molecular (e.g., PCR) or Rapid Antigen Test); or (ii) symptomatic AND a household contact of a confirmed COVID-19 case*	☐ Yes ☐ No
Have you been sick in the past few days? Do you have symptoms of COVID-19 or have a fever today?	☐ Yes ☐ No
Have you had a serious allergic reaction within 4 hours to the COVID19 vaccine before?	☐ Yes ☐ No
Do you have allergies to polyethylene glycol, tromethamine/trometamol (Moderna/Pediatric Pfizer only) or polysorbate or any components of the vaccine?	☐ Yes ☐ No
Have you had a serious allergic reaction to a vaccine or medication given by an injection (e.g., IV, IM), needing medical care?	☐ Yes ☐ No
Do you have a weakened immune system or are you taking any medications that can weaken your immune system (e.g., high dose steroids, chemotherapy)? *If yes, are you receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies, or other targeted agents?*	☐ Yes ☐ No
Do you have a bleeding disorder or are taking blood thinners?	☐ Yes ☐ No
Have you ever felt faint or fainted after receiving a vaccine or medical procedure?	☐ Yes ☐ No
Are you actively receiving monoclonal antibody therapy OR convalescent plasma therapy for the treatment or prevention of COVID-19? *If yes, COVID-19 vaccine should not be given during therapy/treatment*	☐ Yes ☐ No
For children 6 months to 11 years of age: Do you have previous history of multisystem inflammatory syndrome in children (MIS-C), unrelated to any previous COVID-19 vaccination? *(If yes, vaccination should be postponed until clinical recovery has been achieved or until it has been ≥90 days since diagnosis, whichever is longer).*	☐ Yes ☐ No

Consent to Receive the Vaccine:
I have had the opportunity to ask questions regarding the vaccine and to have them answered to my satisfaction. I understand I may withdraw consent at any time.

☐ **I consent to receiving all recommended doses in the series, OR**

☐ **I am a consenting on the patient's behalf to receive all recommended doses in the vaccine series and I confirm that I am the patient's substitute decision maker (e.g., parent, legal guardian).**

Signature of patient/agent	Print Name of patient/agent	Date of Signature

☐ If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker. Relationship to patient:__________________________

FOR PHARMACY USE ONLY:

Brand	Formulation	Age	Packaging	DIN
☐ Moderna Spikevax	Bivalent BA 4/5	5 years +	blue cap / grey label (not dilute)	02532352
☐ Moderna Spikevax	XBB 1.5	6 months +	royal blue cap / coral blue label (not dilute)	02541270
☐ Pfizer Comirnaty	Bivalent BA 4/5	5 to 11 years	orange cap / orange label **(must dilute)**	02533197
☐ Pfizer Comirnaty	Bivalent	12 years +	gray cap and label (not dilute)	02531461
☐ Pfizer Comirnaty	XBB 1.5	12 years +	gray cap and label (not dilute)	02541823
☐ Pfizer Comirnaty	XBB 1.5	5 to 11 years	blue cap and label (not dilute)	02541858
☐ Pfizer Comirnaty	XBB 1.5	6 months to 4 years	maroon cap and label **(must dilute)**	02541866
☐ Novavax Nuvaxovid (only if patient declines mRNA)	Original	12 years +		02525364

Anatomical Site ☐ Left deltoid ☐ Right deltoid	Route (IM) Lot#	Dose (mL)
Date Given ____/____/____ (month, day, year)	Time Given ____ : ____ am pm	AEFI? (after current dose) ☐ Yes ☐ No
Immunizer (Name,Designation)		Immunizer signature