COVID-19 VACCINE ADMINISTRATION SCREENING & CONSENT FORM

Please complete this form and read the information provided before receiving the COVID-19 vaccine. Your answers to these questions will help the Pharmacist determine if the vaccine is appropriate at this time. If you are a parent or guardian providing consent for a child or other person, please complete this information for the person who will be receiving the vaccine. If you have any questions about this form or the vaccine, please speak with the Pharmacist.

Patient Information

First Name: Last Name:

Date of Birth: (dd/mm/yyyy): Age: Sex: ☐ M ☐ F ☐ Other

Address:

Street Apt. City Province

Postal Code

Health Card Number: Telephone Number:

Emergency Contact Name & Telephone Number:

Screening Questionnaire for Person Receiving COVID-19 Vaccine

Question	Answer
Have you been sick or felt unwell in the past few days? Do you have symptoms of COVID-19 or have a fever today?	☐ Yes ☐ No
Have you tested positive for COVID-19 in the last 6 months?	☐ Yes ☐ No
In the last 3 months, have you been admitted to hospital due to COVID-19 and been treated with convalescent plasma or monoclonal antibodies (by IV)?	☐ Yes ☐ No
Have you experienced side effects from a previous dose of a COVID-19 vaccine?	☐ Yes ☐ No
Do you have a history of: - heparin-induced thrombocytopenia (HIT) - thrombosis associated with lupus anticoagulant (thrombotic antiphospholipid syndrome), - capillary leak syndrome - cerebral venous sinus thrombosis (CVST) with thrombocytopenia - or venous arterial thrombosis with thrombocytopenia following a viral vector vaccine (eg, AstraZeneca, COVISHIELD)?	☐ Yes ☐ No
Have you had the diagnosis of myocarditis or pericarditis following a dose of mRNA COVID-19 vaccine (eg, Pfizer, Moderna)?	☐ Yes ☐ No
Have you had a known or suspected allergy, or a severe anaphylactic allergic reaction (eg, difficulty breathing, swelling of mouth or throat, hives) to: - polyethylene glycol (PEG) (found in some cosmetics, skin care products, laxatives, cough syrups, and bowel preparation products for colonoscopy) - polysorbate 80 (found in vitamin oils, tablets, anticancer agents, cosmetics) - tromethamine (tromethamol or Tris) (found in contrast media and medications taken by mouth or injection) - any component of any COVID-19 vaccine	☐ Yes ☐ No
Have you had a severe or anaphylactic reaction (eg, difficulty breathing, swelling of mouth/throat, hives) to any vaccine or injectable therapy in the past?	☐ Yes ☐ No
Are you pregnant, planning to become pregnant, or breastfeeding?	☐ Yes ☐ No
Do you have a medical condition or are you taking medication that affects your immune system (eg, cancer, transplant, HIV, taking corticosteroids)? - 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 taking medications that can affect blood clotting?	☐ Yes ☐ No
Do you have any medical condition(s) that require regular visits to a primary care provider (eg, doctor, nurse practitioner)?	☐ Yes ☐ No
Have you ever felt faint or fainted after receiving a vaccine?	☐ Yes ☐ No
Have you received any vaccines in the past 14 days?	☐ Yes ☐ No

Patient/Agent Consent for Vaccine Administration

I consent to having The Healing Source Pharmacy Pharmacist administer the COVID-19 vaccine. I have reviewed the information about this vaccine and procedure provided to me, and the pharmacist has answered any questions I may have or have had. I understand the risks, benefits, expected outcome(s), and possible side effects of this vaccination and agree to wait in the pharmacy for at least 15 minutes after receiving the vaccine. I agree to see a doctor if I develop any side effects or health problems after receiving the vaccine. I agree that The Healing Source Pharmacy may share my personal health information regarding this vaccination with public health officials and/or other healthcare providers as required.

☐ I am providing consent for myself

☐ I am providing consent for the patient identified above

If providing consent for the patient identified above, please complete the following:

Contact information of patient's agent (name & telephone): ____________________

Relationship: ☐ *Parent* ☐ *Guardian* ☐ *Other (please specify)* ____________________

Name of person providing consent (if other than patient): ____________________

Signature of patient or person providing consent: ____________________ Date: ________ / ________ / ________

dd mm yyyy

Acknowledgement of Collection, Use, and Disclosure of Personal Health Information

The personal health information on this form is being collected for the purpose of providing care to you and creating an immunization record for you, and because it is necessary for the administration of Ontario's COVID-19 vaccination program. This information will be used and disclosed for these purposes, as well as other purposes authorized and required by law. For example,

- it will be disclosed to the Chief Medical Officer of Health and Ontario public health units where the disclosure is necessary for a purpose of the *Health Protection & Promotion Act*. &
- it may be disclosed, as part of your provincial electronic health record, to health care providers who are providing care for you.

The information will be stored in a health record system under the custody and control of the Ministry of Health.

☐ **I acknowledge that I have read and understand the above statement.**

You may be contacted by a hospital, local public health unit, or the Ministry of Health for purposes related to the COVID-19 vaccine (for example, to remind you of follow up appointments and to provide you with a record of immunization). If you consent to receiving these follow up communications by email, please indicate this using the box below.

☐ **I consent to receiving follow-up communications:** ☐ **by email**: ______________________________ ☐ **by text/SMS**

Consent to Being Contacted About Research Studies

You have the option of consenting to be contacted about participation in COVID-19 vaccine related research studies/surveys. If you consent to be contacted, personal health information may be used and your name and contact information will be disclosed to researchers. Consenting to be contacted about research studies does not mean you have consented to participate in the research itself. You may refuse to be contacted about research studies without impacting your eligibility to receive the COVID-19 vaccine.
If you consent to be contacted about research studies, and then change your mind, you may withdraw consent at any time by contacting the Ministry of Health at vaccine@ontario.ca.
This will not impact your eligibility to receive the Covid-19 vaccine.

☐ **I consent to be contacted about COVID-19 vaccine related research studies:** ☐ **by email** (as above) ☐ **by text/SMS** ☐ **by phone** ☐ **by mail**

☐ **I do not consent to be contacted about COVID-19 related research studies**

Name of person providing consent (if other than patient): ______________________________

Signature of patient or person providing consent: ______________________________ Date: _______ / _______ / _________
dd mm yyyy

Pharmacy Use Only – Pharmacist Documentation

COVID-19 vaccine product administered:

☐ Pfizer (Comirnaty) KP.2 - DIN 02541823

☐ Moderna (Spikevax) KP.2 - DIN 02541270

Lot Number: Expiry Date:

No. of previous doses _______________

Date of last dose (dd/mm/yyyy):

Dose: ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ Other: _________

Date of administration (dd/mm/yyyy):

Time of administration: AM / PM

Route and site of administration: ☐ IM Deltoid: ☐ Right ☐ Left ☐ Other:

Patient counselling:

☐ Potential adverse reactions and their management
☐ Importance of adhering to the vaccine schedule
☐ Other comments:

Patient response:
Adverse reaction? ☐ Yes ☐ No
(if yes, describe nature of the reaction and action(s) taken) after 15 minutes?
____

Follow-up
☐ Yes ☐ No ☐ Next dose due: ____________
Details: ______________________________

I confirm that the patient named in this document is capable of providing consent to receive the vaccine indicated or that a parent, guardian, or other agent has provided consent on behalf of the patient. I confirm that this vaccine should be given to the patient based on my assessment.

Affix label here

Name of Pharmacist Administering Vaccine: ______________________________

Pharmacist Licence Number: ____________________ Signature: ______________________________