COVID-19 Vaccine Screening and Consent Form 2025-2026

wholehealth pharmacy partners

Section 1: Patient Information

Name (*First & Last*):	Health Card (OHIP) Number:	
Primary Care Clinician:	Date of Birth (*DD/MM/YYYY*): Age:	Weight: (*if under 18 years old*)
Gender Identity (*If different from Health Card*): ☐ M ☐ F ☐ X	Gender Associated with your Health Card (for billing purposes): ☐ M ☐ F ☐ X	
Address:	Telephone:	
	Emergency Contact (*Name, Phone Number, Relationship*):	

Section 2: Screening Questionnaire

Questions	Yes	No	Unsure
Have you been **sick in the past few days**? (fever > 39.5°C, shortness of breath, chest pain, active infection, or any symptoms of COVID-19)	☐	☐	☐
Are you **allergic** to any of the following? Latex, thimerosal, formaldehyde, TrintonX100, neomycin, kanamycin, gentamycin, polysorbate 80, CTAB (Cetyltrimethylammonium bromide), sodium deoxycholate, sucrose, polyethylene glycol, tromethamine/trometamol	☐	☐	☐
Are you or do you think you might be **pregnant**?	☐	☐	☐
Are you **allergic** to any medications (including vaccines)?	☐	☐	☐
Have you ever fainted or had a serious reaction (including anaphylaxis) to any previous injection or vaccine(s)? If yes, please describe the reaction:	☐	☐	☐
Do you have a **new** or **changing** neurological disorder?	☐	☐	☐
Do you have **a bleeding condition** or use **blood thinners**? (e.g. warfarin, aspirin)	☐	☐	☐
Have you been diagnosed with **myocarditis or pericarditis** within 6 weeks following a previous dose of an mRNA COVID-19 vaccine? *(If yes, further doses of mRNA COVID-19 vaccine should be deferred and consulted with your healthcare provider).*	☐	☐	☐
Have you ever had myocarditis or pericarditis before? *(If yes, consult the risk and benefit of receiving the mRNA COVID-19 vaccine with your healthcare provider).*	☐	☐	☐
Have you had a **previous COVID-19 infection** within the past 8 weeks (or within the past 4 to 8 weeks if you are moderately to severely immunocompromised? *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.*	☐	☐	☐
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?	☐	☐	☐
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).*	☐	☐	☐
Have you received any other non-COVID vaccine (live or non-live) in the past 14 days? If yes, please specify:	☐	☐	☐

Section 3: Immunization Screening Questionnaire (Optional)

Question	Yes	No	Unsure	Question	Yes	No	Unsure
For individuals **over 50 years old,** have you received a **pneumonia** vaccine?	☐	☐	☐	For individuals **10-25 years old**, have you received a **meningitis B** vaccine?	☐	☐	☐
For individuals **over 50 years old,** have you received **shingles** vaccines?	☐	☐	☐	For individuals **9-45 years old**, have you received an **HPV** vaccine (Gardasil 9) before?	☐	☐	☐
For individuals **over 50 years old,** have you received **a RSV** vaccine?	☐	☐	☐	Are your **COVID-19** vaccines up to date?	☐	☐	☐

Section 4: Patient Information

I, the client, parent, or guardian, have read or had explained to me information about the flu/COVID-19 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 flu/COVID-19 vaccine. I understand I may withdraw consent at any time. I agree to wait in the pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the flu/COVID-19 vaccine.

I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called "anaphylaxis" can be life-threatening and are deemed medical emergencies. If I experience such a reaction following vaccination, I am aware that it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 911 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. In the event of anaphylaxis, I will receive a copy of this form containing information on emergency treatments that I had received, or a copy will be provided to my agent or EMS paramedics.

COVID-19 Vaccine:

- ☐ **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)**

Patient/Agent Name (*& Relationship*):	Patient/Agent Signature:	Date Signed (*DD/MM/YYYY*):

Section 5: Pharmacy Use Only

Vaccine administered:

COVID-19 Vaccine:

MODERNA SPIKEVAX
- ☐ Multi-Dose Vial (2.5ml) – DIN: 02541270 (*6mo+*)
- ☐ Pre-Filled Syringe (0.5ml) – DIN: 02557770 (*12yo+*)

PFIZER-BioNTech COMIRNATY
- ☐ Multi-Dose Vial (1.8ml) – DIN: 02541823 (*12yo+*)
- ☐ Pre-Filled Syringe (0.3ml) – DIN: 02552035 (*12yo+*)
- ☐ Single-Dose Vial (0.3ml) – DIN: 02541858 (*5-11yo*)

Anatomical Site ☐ Left arm ☐ Right arm	Route: Intramuscular	Lot #:	Expiry (*MM/YYYY*):
Date Given (*DD/MM/YYYY*):	Time Given: ____:____ AM/PM	AEFI? ☐ No ☐ Yes _____ *(Please specify)*	

Epinephrine
Emergency Use
(Only If Needed)
** Note: Weight is the preferred basis for dosage; use age if weight is unknown*

Epinephrine 0.15 mg*
Children (*age 2-7*):
Weight: 11 to 20 kg (*24 - 45 lbs*)
- ☐ **EpiPen Junior** DIN 00578657
- ☐ **Allerject** DIN 002382059

Epinephrine 0.3 mg*
Children (*age 7-12*):
Weight: 21 to 45 kg (*46 – 100 lbs*)
- ☐ **EpiPen Adult** DIN 00509558
- ☐ **Allerject** DIN 002382067
- ☐ **Emerade** DIN 002458446

Epinephrine 0.5 mg*
Adolescents (*age 12+*) and adults:
Weight ≥ 46 kg (≥ *101 lbs*)
- ☐ **Emerade** DIN 002458454

# of Doses Administered:	Times of Epinephrine Administration: 1. 2. 3.

PHARMACIST DECLARATION:

I confirm the above-named patient is capable of providing consent for seasonal influenza and/or COVID-19 vaccine and that the seasonal influenza and/or COVID-19 vaccine should be given to the patient.

Pharmacist:	License #:	Signature:	Date Signed (*DD/MM/YYYY*):

Recommended doses from Canadian Immunization Guide https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-2-vaccine-safety/page-4-early-vaccine-reactions-including-anaphylaxis.html#t4