Heritage Park Pharmacy : COVID 19 Vaccine Consent & Screening Form

Full Name: **DOB:** **HC#** **Phone #** **Address:**	**Please Complete:** **Date Of First Dose (mm/dd/yyyy):** ______________________________ **First Dose Select:** Pfizer/ Modena/ AstraZeneca **Date of Second Dose(mm/dd/yyyy):** ______________________________ **Second Dose Select:** Pfizer/ Modena/ AstraZeneca	**If Indigenous please indicate:** ○ First Nations ○ Metis ○ Inuk/Inuit ○ Other _______ ○ Unknown ○ Prefer not to answer
Primary Care Clinician:		

Consent to Receive the Vaccine

I have read (or it has been read to me) and I understand the Immunization Prepackage, including the following documents: 'COVID-19 Vaccine Information Sheet' and 'What you need to know about your Covid-19 vaccine appointment'. - I have had the opportunity to ask questions regarding the vaccine I am receiving and to have them answered to my satisfaction.

□ **I consent to receiving the vaccine, including all recommended doses in the series.**

I understand that I may withdraw this consent at any time. - I understand that if I am withdrawing consent as a substitute decision maker of an individual, then I must contact the congregate setting that the individual resides in.

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 and Promotion Act. And - it may be disclosed, as part of your provincial electronic health record, to health care providers who are providing care to you. The information will be stored in a health record system under the custody and control of the Ministry of Health.

Where a Clinic Site is administered by a hospital, the hospital will collect, use and disclose your information as an agent 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**

If you agree please provide your email or test/SMS number: ________________________

Consent to Being Contacted About Research Studies

You have the option of consenting to be contacted by researchers about participation in COVID19 vaccine related research studies. If you consent to be contacted, your personal health information will be used to determine which studies may be relevant to you, 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. Participating in research is voluntary. You may refuse to consent to be contacted about research studies without impacting your eligibility to receive the COVID-19 vaccine. If you do not wish to be contacted about research studies, please indicate this below. 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 ☐ by text/SMS ☐ by phone ☐ by mail

If selected by email, please provide your email address: ________________

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

Screening Questions: Please answer all questions below:

Question	Details
Have you experienced major venous and/or arterial thrombosis with thrombocytopenia following vaccination with any vaccine? **☐ No ☐ Yes**	If yes, please provide details
Have you experienced a previous cerebral venous sinus thrombosis (CVST) with thrombocytopenia or a heparin induced thrombocytopenia (HIT)? **☐ No ☐ Yes**	If yes, please provide details
Have you experienced a previous episode of capillary leak syndrome? **☐ No ☐ Yes**	If yes, please provide details
Have you been diagnosed with myocarditis or pericarditis following the first dose of an mRNA COVID-19 vaccine? **☐ No ☐ Yes**	If yes, please provide details
Have you been sick in the past few days? Do you have symptoms of COVID-19 or have a fever today? **☐ No ☐ Yes**	If yes, please provide details
Have you had a serious allergic reaction within 4 hours to the COVID19 vaccine before? **☐ No ☐ Yes**	If yes, please provide details
Do you have allergies to polyethylene glycol, tromethamine (Moderna only) or polysorbate? **☐ No ☐ Yes**	If yes, please provide details
Have you had a serious allergic reaction to a vaccine or medication given by injection (e.g., IV, IM), needing medical care? **☐ No ☐ Yes**	If yes, please provide details
Have you received another vaccine (not a COVID-19 vaccine) in the past 14 days? **☐ No ☐ Yes**	If yes, please provide details
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)? **☐ No ☐ Yes**	If yes, please provide details

If yes, are you receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies or other targeted agents? ☐ **No** ☐ **Yes**	
Do you have a bleeding disorder or are taking blood thinners? ☐ **No** ☐ **Yes**	If yes, please provide details
Have you ever felt faint or fainted after receiving a vaccine or medical procedure? ☐ **No** ☐ **Yes**	If yes, please provide details

Signature	**Print Name**	**Date of Signature**
If signing for someone other than yourself, indicate your relationship to that other person:		
☐ If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker.		

FOR CLINIC USE ONLY							
Agent	COVID-19	Product Name		Lot #		Dose Amount:	
Anatomical Site	☐ Left deltoid ☐ Right deltoid			Route	Intramuscular (IM)	Dose #:	
Date Given	______ / ______ / ______ (m/d/yyyy)	Time Given	____ : ____ am pm	AEFI? (after receiving current dose)	☐ Yes ☐ No		
Given By (Name, Designation)		Location		Authorized By			
Reason for Immunization	☐ Healthcare Worker ☐ LTC: Resident ☐ LTC: Healthcare Worker ☐ LTC: Other Non- Employee ☐ RH: Healthcare Worker ☐ RH: Resident ☐ RH: Essential Caregiver ☐ RH: Other Non-Employee ☐ Advanced Age: Community Dwelling ☐ Adult of Chronic Health Care ☐ Indigenous community ☐ Other Priority Population ☐ Congregate Living: Resident ☐ Congregate Living: Staff ☐ Congregate Living: Essential Caregiver						
Reason Immunization Not Given	☐ Immunization is contraindicated ☐ Practitioner recommends immunization but no PATIENT consent ☐ Practitioner decision to temporarily defer immunization ☐ Medically Ineligible ☐ Patient withdrew consent for series						
Your next dose is scheduled for:	______ / ______ / ______ (m/d/yyyy) ____ : ____ am pm						