COVID-19 VACCINE ADMINISTRATION SCREENING AND CONSENT FORM

Please complete this form and read the supplemental information provided by the Pharmacist before receiving _____ (name of COVID-19 vaccine). Your answers to these questions will help the Pharmacist determine if the COVID-19 vaccine is appropriate at this time. If you are a legal representative providing consent for another person, please complete this information for the person who will be receiving the COVID-19 vaccination.

PATIENT INFORMATION

Legal First and Last Name:

Age:	Date of Birth: _____ / _____ / _____ (yyyy / mm / dd)	*(collected for clinical assessment & reimbursement)* Sex: ❑ Male ❑ Female ❑ _____ (self-identify)

Address: Street Apartment City Province Postal Code

Health Card #: (Personal Health Identification Number)	Telephone:

Emergency Contact Name and Phone Number:

If you have questions and/or concerns about this form or the COVID-19 vaccine, please speak with the Pharmacist at:

Store Stamp

Screening Questionnaire for Person Receiving COVID-19 Vaccine	Yes	No
If this is your second dose of COVID-19 vaccine, did you have any side effects after the first dose?		
Do you have a known or suspected allergy to polyethylene glycol (PEG)? PEG can be found in some products such as cosmetics, skin care products, laxatives, cough syrups and bowel preparation products for colonoscopy.		
Do you have a known or suspected allergy to polysorbate?		
Do you have a known or suspected allergy to any component of the COVID-19 vaccine?		
Have you had severe or anaphylactic reaction to another vaccine or injectable therapy in the past?		
Have you had severe or anaphylactic reaction not related to vaccines or injectable medications (e.g. food, medication, venom, etc.)?		
Have you received another vaccine (excluding COVID-19 vaccine) in the 14 days before your COVID-19 vaccination appointment?		
Are you pregnant, may be pregnant or are planning on becoming pregnant before receiving both doses of the vaccine?		
Are you breastfeeding?		
Do you have a weakened immune system due to underlying health condition or medication/treatment (e.g. high dose steroids, chemotherapy)?		
Do you have an autoimmune condition (e.g. Rheumatoid Arthritis, Multiple Sclerosis)?		
Do you have any medical conditions that require regular visits to a doctor?		
Do you have a bleeding disorder or are you taking medications that can affect blood clotting (e.g. blood thinner)?		
Have you ever felt faint or fainted after past vaccination or medical procedure?		

COVID-19 Screening

I confirm that I:

❑ Have not experienced any symptoms of COVID-19 detailed in the list presented to me in the past 10 days

❑ Have not travelled outside of Canada or provincially mandated travel restrictions in the past 14 days

❑ Have not been in contact with someone known to have COVID-19 in the past 14 days

COVID-19 Vaccine Administration

I consent to have the Pharmacy Professional administer the COVID-19 vaccine to the individual named above. I agree to ask the Pharmacist any questions I may have about the COVID-19 vaccine or vaccine administration prior to receiving the vaccination. I have reviewed the COVID-19 vaccine information provided to me. I understand the risks, benefits, expected outcome and possible side effects of this vaccine and agree to wait in the pharmacy for at minimum 15 minutes after receiving the vaccination. I agree that the pharmacy may share my personal health information regarding this vaccination as required with public health officials and other healthcare providers.

❑ I am providing consent for myself

❑ I am providing consent for the patient identified above.

If providing consent for patient identified above, complete below:

Contact information of patient agent (name and telephone): _____

Relationship to person receiving this COVID-19 vaccination:

❑ *Parent* ❑ *Guardian* ❑ *Other, please specify* _____

Name of person providing consent: _____

Signature of person providing consent: _____

Date: _____ / _____ / _____ (yyyy / mm / dd)

Pharmacy Use Only – COVID-19 VACCINE	
COVID-19 Vaccine Product: Manufacturer: DIN:	Date of administration (yyyy/mm/dd): Time of administration: _____ AM/PM
Lot number:	Route and site of administration: Intramuscular (IM)
Expiry Date (yyyy/mm/dd):	Deltoid: ❑ Right ❑ Left Other: _____
# of total doses required:	Dose: ❑ First Dose ❑ Second Dose
Rationale for COVID-19 Vaccination administered Indicated for active immunization against coronavirus disease 2019 (COVID-19) caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus	
Patient counseling	❑ Potential adverse reactions and their management ❑ Reinforce the importance of adhering to vaccine schedule If applicable: ❑ Pregnancy ❑ Breastfeeding ❑ Autoimmune condition ❑ Immunosuppressed ❑ 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 *(If yes, describe the reason for follow-up and timing)* _____

I confirm that the patient named in this document is capable of, and has provided consent to, receive this COVID-19 vaccine indicated in this document, or that a parent/guardian or other agent has provided consent on behalf of the patient. I confirm that this COVID-19 vaccine should be given to the patient based on my assessment. I confirm that the patient/agent has provided informed consent.

Pharmacist Signature: _____

Name and Title of Pharmacy Professional Administering COVID-19 vaccine: _____

License Number: _____ Signature: _____