COVID-19 VACCINE SCREENING & CONSENT FORM

Today's Date (yyyy/mm/dd):

Clinic Location/Facility Name:

Concord Specialty Pharmacy
4-2180 Steeles Avenue W.
Concord, ON L4K 2Z5

CLIENT INFORMATION					
First Name:				Last Name:	
Date of Birth:	Year	Month	Day	**Age**	☐ Male ☐ Female ☐ Other
Health Card #				Email:	
Address:				Postal Code:	Primary Phone:

SCREENING QUESTIONS		
Do you have symptoms of COVID-19 or feel ill today?	☐ Yes	☐ No
Have you previously had a severe allergic reaction (e.g. anaphylaxis) to a previous dose of a COVID mRNA vaccine or to any of its components or its container?	☐ Yes	☐ No
Do you have a suspected hypersensitivity or have you had an immediate allergic reaction *(this would include an allergic reaction that occurred within 4 hours that cause hives, swelling, or respiratory distress, including wheezing*) **to:**		
• **A previous dose of an mRNA COVID-19 vaccine**	☐ Yes	☐ No
• **Any components of the mRNA COVID-19 vaccine (including polyethylene glycol [PEG])****	☐ Yes	☐ No
• **Polysorbate (due to potential cross-reactive hypersensitivity with the vaccine ingredient PEG)****	☐ Yes	☐ No
Have you ever had a severe (e.g. anaphylaxis) or an immediate allergic reaction to any other vaccine or injectable therapy? *(this would include an allergic reaction that occurred within 4 hours that cause hives, swelling, or respiratory distress, including wheezing)*	☐ Yes	☐ No
Have you ever had a severe allergic reaction (e.g. anaphylaxis) not related to vaccines or injectable medications – such as allergies to food, pet, venom, environmental, or latex etc.?	☐ Yes	☐ No
Have you received a vaccine in the past 14 days?	☐ Yes	☐ No
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Do you have any problems with your immune system or are you taking any medications that can affect your immune system (e.g., high dose steroids, chemotherapy)?	☐ Yes	☐ No
Do you have an autoimmune disease?	☐ Yes	☐ No
Do you have a bleeding disorder or are taking medications that could affect blood clotting (e.g., blood thinners)?	☐ Yes	☐ No
Have you ever felt faint or fainted after a past vaccination or medical procedure?	☐ Yes	☐ No

CONSENT & COLLECTION OF INFORMATION

For individuals receiving a different mRNA vaccine for their second dose following Pfizer BioNTech or Moderna:
The same mRNA COVID-19 vaccine product should be offered for the second dose in a vaccine series started with an mRNA COVID-19 vaccine if available in the clinic. If the mRNA COVID-19 vaccine used for the first dose is not readily available in the clinic or is unknown, another mRNA COVID-19 vaccine product can be considered interchangeable and will be offered to complete the vaccine series. You will be advised which vaccine is being offered before receiving the dose ☐ ***I acknowledge that I have read and understand this information***

For individuals choosing to receive an mRNA vaccine following AstraZeneca COVID-19 vaccine:
Individuals who received AstraZeneca for their first dose may choose to receive either AstraZeneca for their second dose or an mRNA vaccine. A dosing interval between eight and 12 weeks is safe and demonstrates a beneficial immune response. There is evidence that a longer interval between two doses of the AstraZeneca vaccine (such as a 12-week interval) provides higher protection ☐ ***I acknowledge that I have read and understand this information***

I have read The Regional Municipality of York's (York Region Public Health's) COVID-19 Vaccine Information Sheet or it has been read to me. I understand the benefits and possible side effects of the vaccine and that certain persons listed on the Information Sheet should not get the COVID-19 vaccine. I have had an opportunity to have my questions answered from a representative of the clinic location/facility. ☐ ***I consent to receiving the COVID-19 vaccine***

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.

☐ ***I acknowledge that I have read and understand the above statement.***
You may be contacted for purposes related to the COVID-19 vaccine (for example, to remind you of follow up appointments and to provide you with proof of vaccination).

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

Consent to Being Contacted About Research Studies

You have the option of consenting to be contacted by researchers about participation in COVID-19 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 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 consent to be contacted about research studies, and then change your mind, you may withdraw your consent at any time by contacting the Ministry of Health at Vaccine@ontario.ca.

☐ ***I consent to be contacted about COVID-19 vaccine related research studies:***
☐ ***by email*** ☐ ***by text/SMS*** ☐ ***by phone*** ☐ ***by mail***
☐ ***I do not consent to be contacted about COVID-19 related research studies***

Client Signature:	**Date signed:**

PARENT/LEGAL GUARDIAN/SUBSTITUTE DECISION MAKER (SDM) CONSENT - Required for youth and adults who are unable to provide their own consent

If applicable: Parent/Legal Guardian/SDM Full Name:	**If applicable: Parent/Legal Guardian/SDM Signature:**	**Date Signed:**

For Clinic Use Only: Complete this section if vaccine administration is not entered into COVAX

Client Full Name:	**Client DOB:**
COVID-19 Product Name:	**Lot #**
Diluent Lot # ☐N/A	**Dose:** ☐0.3mL ☐0.5mL ☐Other:
Route and Anatomical Site: ☐IM – Right Deltoid ☐IM – Left Deltoid ☐IM – Other:	
Date given (yyyy/mm/dd):	**Time given:**
Dose Number: ☐One ☐Two	**AEFI after receiving current dose?** ☐Yes ☐No

Reason for Immunization:

☐Healthcare worker	☐Other priority population	☐Indigenous community
☐LTC Resident	☐RH Essential caregiver	☐Congregate living resident
☐LTC Healthcare worker	☐RH non-employee	☐Congregate living staff
☐LTC Other non-employee	☐Advanced age- community dwelling	☐Congregate living essential caregiver
	☐Adult of chronic homecare	☐RH Healthcare worker

Reason for Paper Documentation:

☐ No consent for COVax entry	☐ COVax unavailable	☐ other_____

Immunizer Full Name and Designation:

Immunizer Signature:

Complete below if immunization not given

Reason immunization not given:

- ☐ Immunization is contraindicated
- ☐ HCP decision to temporarily defer immunization
- ☐ Medically ineligible
- ☐ Client withdrew consent
- ☐ HCP recommends immunization but no client consent
- ☐ Below minimum monograph age

For ACI/office use only to document post-clinic data entry into COVax as appropriate	Date/time entered **(office use only)**	Printed Name **(office use only)**