

COVID-19 CONSENT FOR IMMUNIZATION

VACCINE GIVEN: _____

DATE: _____

DOSE ___ of ___ (write 1 of 1 if not part of a series)

1 CLIENT INFORMATION Complete Sections 1, 2, and 3 (please print)

Last Name:		First Name:		Date of Birth (YYYY/MM/DD):	
Address:			Telephone Number:		
Emergency Contact and Relation:			Emergency Telephone Number:		
Personal Health Number:		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Prefer not to say		Pregnancy Status: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	

2 Contraindications

*A condition in a recipient that increases the risk for a serious adverse event. In general, a vaccine should not be administered when a contraindication is present. ****Note:** The only contraindication to receipt of a COVID-19 vaccine is a history of anaphylaxis to a previous dose or to a component of the vaccine.*

1. Do you have any allergies?

No Yes

If yes, please provide details:

1a. If yes: Do you have a severe allergy to:

No Yes

If yes, please provide details

- Polyethylene glycol (PEG) - contained in the Moderna and Pfizer- BioNTech COVID-19 vaccines. PEG can be found in some cosmetics, skin care products, laxatives, cough syrups, and bowelpreparation products for colonoscopy. PEG can be an additive in some processed foods and drinks but no cases of anaphylaxis to PEG in foods and drinks have been reported.

- Polysorbate 80 – contained in the AstraZeneca and Verity Pharmaceuticals vaccines. It is also found in medical preparations (e.g., vitamin oils, tablets and anticancer agents) and cosmetics.

1b. If yes to #1, have you had anaphylaxis (severe allergy) from an unknown cause? Were you seen by an allergy specialist?

If anaphylaxis without known or obvious cause, consider referral to an allergist prior to immunization.

Precautions: *A condition in a recipient that might increase the risk for a serious adverse reaction or might compromise the ability of the vaccine to produce immunity. When a precaution is present, further assessment and a risk-benefit analysis may be necessary.*

2. 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)?

No Yes

If yes to any of these questions, a complete COVID-19 vaccine series may be offered if a risk assessment deems that the benefits outweigh the potential risks for the individual, and if informed consent includes discussion

3. Do you have an autoimmune condition?

about the absence of evidence on the use of COVID-19 vaccine in these populations.

4. Are you or could you be pregnant?

5. Are you breastfeeding?

6. Have you been hospitalized because of COVID-19 infection? If yes, were you treated with convalescent plasma or monoclonal antibody within the last 3 months?

No Yes

If yes, COVID-19 vaccination should be deferred for at least 90 days following receipt of these antibody treatments.

7a. Is this your first dose of a COVID-19 vaccine or second dose?

First Second

If second dose when was the first dose received:
Which vaccine was received:

7b. If this is your second dose, did you have any allergic reactions after the first dose, or side effects for which you sought medical attention?

No Yes

If yes, please provide details

Special Considerations

8. Are you feeling ill today?

No Yes

If yes, what symptoms?

9. Have you had previous lab-confirmed COVID-19 disease within the last 3 months?

No Yes

If yes, when?

10. Have you ever felt faint or fainted after a past vaccination or medical procedure?

No Yes

If yes, please provide details

3 CONSENT

Client Parent Legal Guardian Representative

I understand that I will be asked at the appointment to provide consent for the vaccination.

I will stay as directed by the pharmacist after the vaccination and seek medical attention if needed.

I will report any adverse effects I experience to the immunizing pharmacist.

Name: (PRINT) _____ Phone: _____

Signature: _____ Date Signed (YYYY/MM/DD): _____

FOR PHARMACIST USE ONLY

The patient was provided and understood information about the vaccine listed below. They understand the benefits and possible reactions to the vaccine and the risk of not getting immunized. They have been informed of any medical reason why the vaccine listed below should not be given to them/their child. They have had the opportunity to ask questions that were answered to their satisfaction. They gave their consent voluntarily and understand that this consent is valid for the vaccine listed below.

3. VACCINE INFORMATION

Name of vaccine: _____ DIN: _____

Dose (mL): _____ Site: LA RA Route: IM SC ID IN

Lot #: _____

Expiry date (YYYY/MM/DD): _____

LA left arm; RA right arm; IM intramuscular; SC subcutaneous; ID intradermal; IN intranasal

Pharmacy Label

4. PHARMACY INFORMATION

Pharmacy: _____

Phone: _____

Address: _____

Pharmacist signature: _____

License number: _____

Date of administration (YYYY/MM/DD): _____

Time of administration: _____

5. CLIENT RESPONSE

Before: Normal Yes No

15-30 mins post-administration: Normal Yes No

During: Normal Yes No

Other comments: _____