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: ☐ Female ☐ Male ☐ Prefer not to say	Pregnancy Status: ☐ No ☐ Yes ☐ 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 ☐
1a. If yes: Do you have a severe allergy to: • 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.	If yes, please provide details:
1b. If yes to #1, have you had anaphylaxis (severe allergy) from an unknown cause? Were you seen by an allergy specialist?	No ☐ Yes ☐ If yes, please provide details 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 about the absence of evidence on the use ofCOVID-19 vaccine in these populations.
3. Do you have an autoimmune condition?	
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 monoclonalantibody 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 withinthe last 3 months?	No ☐ Yes ☐ If yes, when?
10. Have you ever felt faint or fainted after a past vaccination ormedical procedure?	No ☐ Yes ☐ If yes, please provide details

❸ 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 beeninformed 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: _____