COVID-19 SCREENING AND CONSENT FORM

1. CLIENT INFORMATION

Client's Last Name:		Client's First Name:	
Date of Birth (YY-MM-DD):	Health Card #:	☐Male ☐Female ☐Prefer not to answer	
Address:			Postal Code:
Name of Parent/Legal Guardian (for child):		Relationship to Child:	Cell/Home Phone:

2. SCREENING INFORMATION

Question		
Do you have symptoms of COVID-19 or have a fever today?	☐YES	☐NO
Are you pregnant or breastfeeding?	☐YES	☐NO
Have you received any other vaccine in the past 14 days	☐YES	☐NO
In the last 6 months, have you previously tested positive for a COVID-19 infection	☐YES	☐NO
Have you ever felt faint or fainted after receiving a vaccine or medical procedure	☐YES	☐NO
Have you experienced serious side effects from a previous COVID-19 vaccine?	☐YES	☐NO
Have you had a severe or anaphylactic reaction to another vaccine in the past? (e.g., difficulties breathing, itchy/swelling of mouth or throat, hives)	☐YES	☐NO
In the last 3 months, have you previously been admitted to the hospital due to a COVID-19 infection and treated with convalescent plasma or monoclonal antibodies (received treatment intravenously [by IV])	☐YES	☐NO
Do you have a history of any of the following: - heparin-induced thrombocytopenia (HIT) or - thrombosis associated with lupus anticoagulant (thrombotic antiphospholipid syndrome) or - capillary leak syndrome or - cerebral venous sinus thrombosis (CVST) with thrombocytopenia or - multisystem inflammatory syndrome in children (MIS-C) or - venous or arterial thrombosis with thrombocytopenia following a viral vector vaccine (e.g., AstraZeneca, COVISHIELD vaccines) - myocarditis or pericarditis following the first dose of mRNA COVID-19 vaccine (e.g., Pfizer, Moderna)	☐YES	☐NO
Do you require a tuberculin skin testing (TST) or interferon gamma release assay (IGRA) test within the next 4 weeks?	☐YES	☐NO
Do you have a known or suspected allergy to any components of the vaccine? (e.g., tromethamine, polysorbate 80 or polyethylene glycol [PEG])	☐YES	☐NO
Are you taking any medications that can weaken your immune system? (e.g., high dose steroids, anticancer or transplant medications)	☐YES	☐NO
Do you have an autoimmune condition? (e.g., rheumatoid arthritis, multiple sclerosis, Crohn's disease, lupus)	☐YES	☐NO
Do you have a bleeding disorder or are you taking medications that can affect blood clotting (e.g., blood thinner including: Aspirin, warfarin, Eliquis, Lixiana, Pradaxa, Xarelto)	☐YES	☐NO
Some of these questions are unclear to me, I would like to discuss this with the pharmacist	☐YES	☐NO

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3. CONSENT FOR VACCINATION (clients 14 years or older can sign their own consent):

I have read (or it has been read to me) and I understand the 'COVID-19 Vaccine Information Sheet'. I have had the opportunity to ask questions and to have them answered to my satisfaction. ☐ I consent to receiving the vaccine	**The personal health information on this form is being collected for the purpose of providing care to you. It will be used and disclosed for this purpose, 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.** ☐ I acknowledge that I have read and understand the above statement.	**The hospital, local public health units and the Ministry of Health may wish to communicate with you for purposes related to the COVID-19 vaccine (for example, communications to remind you of follow-up appointments, to provide you with proof of vaccination, and to tell you about research projects.) I consent to receiving communications by:** ☐ email ☐ phone/SMS
Signature:	**Print Name:**	**Date of Signature (DD/MM/YYY):**
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 have the legal authority to provide consent for the individual that is to receive the COVID-19 vaccine (i.e., you are a parent, legal guardian, or substitute decision maker)

FOR CLINIC USE ONLY			
Agent	Product Name	Lot #	Expiry Date (DD/MM/YYYY)
COVID-19			
Anatomical Site		Route	Dosage
☐ Left deltoid	☐ Right deltoid	Intramuscular	
Date Given (DD/MM/YYY)		Time Given	AEFI (After receiving current dose)
			☐ Yes ☐ No
Given By			