Consent Form for Moderna COVID−19 Vaccine (mRNA−1273 SARS−CoV−2 Vaccine); Pfizer−BioNTech COVID−19 Vaccine (COVID−19 mRNA Vaccine) (Version 12. 2021SEP08)

Client Information

Full Name: _____ Preferred Name / Alias: _____

Health Card Number: _____

Street Address: _____ City / Town: _____

Province: _____ Postal Code: _____

Phone Number: _____ Email Address: _____

Date of Birth: _____ (YYYY/MON/DD) Age: _____

Gender: ❑ Male ❑ Female ❑ Gender X ❑ Undifferentiated ❑ Unknown

Name of Health Care Facility

If you are a resident / client of a facility, in what facility do you live? _____

For Health Care Workers (HCW) only

Job Title: _____ **Employee #:** _____

Department / Unit: _____

Do you work in: ❑ **HCW Acute Care** ❑ **HCW Long Term Care** ❑ **HCW Community−based**

Employer Name: _____ **Zone:** _____

Please check one of the categories below if they apply to you:

❑ Staff Physician
❑ Resident or Medical Student
❑ Nurse Practitioner (NP)
❑ RN / LPN / CCA / CTA
❑ Dentist / Dental Hygienist / Dental Assistant
❑ Pharmacist / Pharmacy Technician / Pharmacy Assistant
❑ Allied Health Professional (e.g. OT, PT, Social Work)
❑ Administrative
❑ Support Services (e.g. Porter, Housekeeping, Food & Nutrition)
❑ Volunteer
❑ Contract Worker − Specify: _____
❑ Learner / Student

Specify School: _____ Program: _____ Year (1st, 2nd, etc.): _____

❑ Other: _____

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Vaccine Dose
Is this your **first or second dose** of the COVID−19 vaccine? ❑ First ❑ Second
If **second**, please indicate the date and name of the first vaccine, if known: _____ (Date (YYYY/MON/DD)) _____ (Name)

Answer the following questions before meeting with the vaccine provider:

Are you feeling ill today?	❑ No ❑ Yes *If yes, please provide details:*
Have you ever suffered an anaphylactic reaction (severe allergic reaction) to a vaccine or another injectable medication? *If you answer **Yes**, you may be vaccinated today, but will be observed for 30 minutes after getting your vaccination.*	❑ No ❑ Yes *If yes, please provide details:*
Pfizer−BioNTech and Moderna COVID−19 Vaccines: Have you ever experienced anaphylaxis (severe allergic reaction) to Polyethylene Glycol (PEG)* or any other ingredient in the vaccine? ** In rare cases, Polyethylene glycol (PEG) can cause allergic reactions. It is found in products such as medications, bowel preparation products for colonoscopy, laxatives, cough syrups, cosmetics, skin creams, dermal fillers, medical products used on the skin and during operations, and contact lens solution.*	❑ No ❑ Yes *If yes, please provide details:*
Moderna COVID−19 Vaccines: Have you ever experienced anaphylaxis (severe allergic reaction) to Tromethamine (trometamol or Tris) or any other ingredient in the vaccine? ** Tromethamine is a component in contrast media, oral and parenteral medications.* *Tell the health care provider if you are allergic to anything that may **contain Polyethylene Glycol, Tromethamine.*** *If you answer **Yes** to any of the above questions you will not be able to be vaccinated today. You will need to be assessed by a health care provider to ensure that it is safe for you to receive this vaccine.* *You cannot get the vaccine (**contraindicated**) if you have a known allergy to any component of the vaccine, including Polyethylene Glycol (PEG), Tromethamine (trometamol or Tris).*	❑ No ❑ Yes ❑ Not applicable *If yes, please provide details:*

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*There have been rare cases of **myocarditis** (inflammation of the heart muscle) and **pericarditis** (inflammation of the lining around the heart) following vaccination with Pfizer−BioNTech and Moderna COVID−19 vaccines reported in Canada and internationally. Some data suggests that this occurs more frequently following the Moderna COVID−19 vaccine compared to the Pfizer−BioNTech vaccine.* Have you reviewed the Important Information Sheet about Myocarditis and Pericarditis? http://policy.nshealth.ca/Site_Published/covid19/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=88001	❑ No ❑ Yes
If this is your second dose of an mRNA vaccine, did you experience myocarditis and / or pericarditis following your first dose or either Pfizer or Moderna COVID−19 vaccine? As a precaution, the National Advisory Committee on Immunization (NACI) recommends that individuals who experienced myocarditis and / or pericarditis after a first dose of an mRNA vaccine **should wait** to get their second dose until more information is available.	❑ No ❑ Yes ❑ Not applicable for first dose *If yes, please provide details:* ❑ No, I choose not to receive the Pfizer / Moderna COVID−19 vaccine at this time. ❑ Yes, I have read the information and wish to receive my second dose of Pfizer / Moderna COVID−19 vaccine at this time despite the recommendation to defer the second dose. ❑ Not applicable for first dose
Do you have a history of myocarditis or pericarditis and are still being followed by a physician for related heart issues?	❑ No ❑ Yes ***If yes, you should follow up with your provider before receiving the vaccine.***
If this is your second dose, did you experience any serious side effects after the first dose?	❑ No ❑ Yes ❑ Not applicable *If yes, please provide details:*

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Are you or could you be pregnant? *A complete mRNA COVID−19 vaccine series (Pfizer or Moderna) is the preferred vaccine for pregnant people.* *There is accumulating information on the safety of the COVID−19 vaccine in pregnancy and there have not been any unique safety concerns raised about negative health effects from vaccine for pregnant people or their babies.* *Evidence is showing that pregnant people develop immunity from COVID−19 vaccines in the same way as non−pregnant people and that vaccination in pregnancy may provide some protection for their babies.* *If you answered **"YES"** to this question, please review the "Vaccine Information for Pregnant People".* http://policy.nshealth.ca/Site_Published/covid19/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=83947	❑ No ❑ Yes
Are you breastfeeding? *A complete mRNA COVID−19 vaccine series is recommended for people who are breastfeeding.* *There is accumulating information on the safety of the COVID−19 vaccine in breastfeeding people and their infants and there have not been any unique safety concerns raised about negative health effects from vaccine for breastfeeding people or their babies.* *Evidence is showing that antibodies from mRNA COVID−19 vaccines are present in breast milk after maternal vaccination with mRNA vaccines which may provide some protection for breastfed babies.* *If you answered **"YES"** to this question, please review the "Vaccine Information for Pregnant People".* http://policy.nshealth.ca/Site_Published/covid19/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=83947	❑ No ❑ Yes

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Do you have problems with your immune system or are you taking any medications that can affect your immune system (i.e. high dose steroids, chemotherapy)? *A complete mRNA COVID−19 vaccine series (Pfizer or Moderna) is the preferred vaccine for people who are immunosuppressed.* *People who are immunocompromised (have a weak immune system) were not included in the trials testing COVID−19 vaccines, however immunocompromised people have received Pfizer and Moderna mRNA vaccines during the pandemic. There have not been any unique safety concerns raised about negative health effects from vaccine for immunocompromised people.* *It is important to be aware that people who are immunocompromised may have a diminished or a delayed response to a COVID−19 vaccine.*	❑ No ❑ Yes
Do you have an autoimmune disease? *A complete mRNA COVID−19 vaccine series (Pfizer or Moderna) is the preferred vaccine for people who have an autoimmune disorder.* *Emerging data suggests that people with an autoimmune condition and normal immune system have a similar response to a COVID−19 vaccine than people without these conditions.* *Few people who have an autoimmune condition were included in the trials testing COVID−19 vaccines, however people with autoimmune conditions have received Pfizer and Moderna mRNA vaccines during the pandemic.* *There have not been any unique safety concerns raised about negative health effects from vaccine for autoimmune individuals.*	❑ No ❑ Yes
Do you have a bleeding disorder or are you taking medications that could affect blood clotting?	❑ No ❑ Yes

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Have you ever felt faint after a past vaccination or medical procedure?	❑ No ❑ Yes
Have you received treatment for COVID−19 with Bamlanivimab? *If you answered **YES**, please provide the date.* *There is insufficient evidence on the receipt of both a COVID−19 vaccine and anti−SARS−CoV−2 monoclonal antibodies (Bamlanivimab).* *Administration of Bamlanivimab and COVID−19 vaccine close together may result in decreased effectiveness of both the vaccine and the treatment.* *Expert clinical opinion should be sought on a case by case basis.*	❑ No ❑ Yes Date: _____ (YYYY/MON/DD)
Have you received another vaccine (not a COVID−19 vaccine) within 14 days of your vaccine appointment? *NACI recommends that COVID−19 vaccines should not routinely be given **at the same time** with other vaccines but notes that there may be circumstances in which simultaneous administration, or a shortened interval may be warranted on an individual basis.* ***A healthcare professional can help to determine timing of COVID−19 vaccines with non−COVID−19 vaccines.***	❑ No ❑ Yes *If yes, please provide details (which vaccine and date):* Date (YYYY/MON/DD):_____
Do you require assistance at your appointment for reduced mobility?	❑ No ❑ Yes

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DO NOT SIGN THIS CONSENT UNTIL THE TIME OF YOUR IMMUNIZATION
The immunizer will provide information about which
COVID−19 vaccine you will receive.

I have read (or it has been read to me) and I understand the "COVID−19 Vaccine Information Sheet".
http://policy.nshealth.ca/Site_Published/covid19/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=84320

I have had the opportunity to ask questions and to have them answered to my satisfaction. I consent to receiving two doses of COVID−19 vaccine:

Are you consenting for yourself? ❑ Yes ❑ No

If no:

❑ I confirm that I am the parent / legal guardian or substitute decision maker.

How are you related to the person you are completing this consent for?

❑ Parent
❑ Child
❑ Foster parent
❑ Legal guardian
❑ Step parent
❑ Substitute Decision Maker
❑ Other: _____

Signature: _____ Print Name: _____

Date: _____
(YYYY/MON/DD)

Continue to next page for additional questions

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Answering the following OPTIONAL questions will help us understand the populations receiving the COVID−19 vaccine.

Demographic Information

Nova Scotia Health−Public Health is using the National Advisory Committee on Immunization Guidelines to ensure early immunization for key populations.

Information will be pooled together so we can monitor and report on the progress of the provincial immunization program including data on which groups of citizens have been immunized.

Any public reporting of this information will be done in a way that prevents the identification of individuals.

We are collecting this information in a way that respects Nova Scotia's health and information privacy laws.

Documentation will be secured following Nova Scotia Health guidelines.

The following questions are OPTIONAL and will not impact the services or care that you receive.

Please check the following boxes that apply to you.

1. Do you have any **underlying medical conditions** (heart disease, lung disease, cancer, high blood pressure, diabetes, problems with your immune system, taking medication that affect your immune system, kidney disease, liver disease)?

5. ❑ Yes ❑ No ❑ Not certain ❑ Prefer not to answer

2. Do you live in a **group living setting**, such as a long term care facility, group home, or shelter?
   ❑ Yes ❑ No ❑ Not certain ❑ Prefer not to answer

3. What is your **occupation?**

   This information is being requested to help determine if the vaccine is being made available to people whose jobs put them at risk for becoming infected with COVID−19.

6. ❑ Management occupations
   ❑ Business, finance and administration occupations
   ❑ Natural and applied sciences and related occupations
   ❑ Health occupations
   ❑ Occupations in education, law and social, community and government services
   ❑ Occupations in art, culture, recreation and sport
   ❑ Sales and service occupations
   ❑ Trades, transport and equipment operators and related occupations
   ❑ Natural resources, agriculture and related production occupations
   ❑ Occupations in manufacturing and utilities
   ❑ Other, please specify: _____
   ❑ Prefer not to answer

4. **Race / ethnicity:** Which race category best describes you?

   We know that people of different races do not have significantly different genetics. But our race still has important consequences, including how we are treated by different individuals and institutions.

   - ❑ Prefer not to answer
   - ❑ African Nova Scotian descent
   - ❑ Black (e.g. African, Afro−Caribbean, African Canadian descent)
   - ❑ East / Southeast Asian (e.g. Chinese, Korean, Japanese, Taiwanese descent or Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian descent)
   - ❑ Indigenous (e.g. First Nations, Inuk / Inuit, Métis descent)
   - ❑ Latino (e.g. Latin American, Hispanic descent)
   - ❑ Middle Eastern (e.g. Arab, Persian, West Asian descent − i.e. Afghan, Egyptian, Iranian, Lebanese, Turkish, Kurdish)
   - ❑ South Asian (e.g. South Asian descent − i.e. East Indian, Pakistani, Bangladeshi, Sri Lankan, Indo−Caribbean)
   - ❑ White (e.g. European descent)
   - ❑ Other, specify: _____
   - ❑ Unknown

5. **Do you identify as Indigenous?**

   ❑ Prefer not to answer ❑ Yes ❑ No ❑ Unknown

   If Yes, indicate which Indigenous Identity:

   - ❑ Mi'Kmaq
   - ❑ First Nations
   - ❑ Métis (includes member of a Métis organization or Settlement)
   - ❑ Inuk / Inuit
   - ❑ Other Indigenous, specify: _____

6. Do you reside in a **First Nations Community** (on reserve or Crown land) or **Inuit Community**?

   ❑ Prefer not to answer ❑ Yes ❑ No ❑ Unknown

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For Immunizer Use Only

VACCINE DOSE #1	DOSE	LOT NUMBER	EXPIRY DATE (YYYY/MON/DD)	SITE and ROUTE	TIME GIVEN	DATE GIVEN (YYYY/MON/DD)	GIVEN BY Name and Designation
Moderna COVID−19 Vaccine (mRNA−1273 SARS−CoV−2 vaccine)	0.5 mL						
Pfizer−BioNTech COVID−19 Vaccine (COVID−19 mRNA Vaccine)	0.3 mL						

Comments:

VACCINE DOSE #2	DOSE	LOT NUMBER	EXPIRY DATE (YYYY/MON/DD)	SITE and ROUTE	TIME GIVEN	DATE GIVEN (YYYY/MON/DD)	GIVEN BY Name and Designation
Moderna COVID−19 Vaccine (mRNA−1273 SARS−CoV−2 vaccine)	0.5 mL						
Pfizer−BioNTech COVID−19 Vaccine (COVID−19 mRNA Vaccine)	0.3 mL						

Comments:

Any legal notice required including with regard to confidentiality of the information.