CONSENT FORM PEDIATRIC (AGES 5−11) PFIZER COMIRNATY (COVID−19 mRNA VACCINE)

(Version 1. 2021NOV26)

Child's Information:

Full Name: _____ Preferred Name / Alias: _____

Health Card Number: _____

Street Address: _____ City / Town: _____

Province: _____ Postal Code: _____

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

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

Parent / Legal Guardian:

Name: _____

Cell Number: _____ Alternate Number: _____

Email Address: _____

Vaccine Dose

Is this your child's first or second dose of the COVID−19 vaccine? ❑ First ❑ Second

If this is the second dose, please indicate the name and date of the last dose of vaccine, if known.

Name: _____ Date (YYYY/MON/DD): _____

Please answer the following questions before meeting with the vaccine provider:

Is your child feeling ill today?	❑ No ❑ Yes *If yes, please provide details:*
Has your child been diagnosed with Multisystem Inflammatory Syndrome in Children (MIS−C) in the past?	❑ No ❑ Yes *If yes, please provide date of diagnosis:* Date: _____ (YYYY/MON/DD) *If yes, you should follow−up with your child's health care provider before they receive the vaccine. It is recommended to wait to be vaccinated until recovery of MIS−C or 90 days after diagnosis of MIS−C, whichever is longer.*
Has your child ever experienced anaphylaxis (severe allergic reaction) to Polyethylene Glycol (PEG)*, Tromethamine (trometamol or Tris) or any other ingredient in the vaccine?	❑ No ❑ Yes *If yes, please provide details:*

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** In very 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.* ** Tromethamine is a component in contrast media, oral and parenteral medications.* *Tell the health care provider if your child is allergic to anything that may **contain Polyethylene Glycol (PEG) or Tromethamine.*** *If you answer **Yes** to any of the above questions your child will not be able to be vaccinated today. Your child will need to be assessed by a health care provider to ensure that it is safe for your child to receive this vaccine.*	
Has your child suffered an anaphylactic reaction (severe allergic reaction) to a vaccine or another injectable medication? *If you answer YES, your child may be vaccinated today, but will be observed for **30 minutes** after receiving the vaccination. (Children with a diagnosed food allergy can receive the COVID−19 vaccine without this prolonged observation time.)*	❑ No ❑ Yes *If yes, please provide details:*
Please indicate your child's weight in kg.	Child's weight: _____ kg. Date child's weight obtained: _____ (YYYY/MON/DD)
Myocarditis / Pericarditis *Rare cases of myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the lining around the heart) following vaccination with COVID−19 mRNA vaccines have been reported with the adolescents / adult formulation. These rare cases occur more commonly after the second dose, among males and among adolescents and young adults, and after Moderna compared with Pfizer.* *Information regarding the occurrence of myocarditis and pericarditis following COVID−19 mRNA vaccination in 5−11 year olds is unavailable at this time. Health Canada, the Public Health Agency of Canada (PHAC), Nova Scotia, and vaccine manufacturers continue to closely monitor the safety of COVID−19 vaccines.*	

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If this is your child's second dose of the Pfizer−BioNTech COVID−19 vaccine, did they experience myocarditis and / or pericarditis following their first dose of Pfizer−BioNTech 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 next dose until more information is available.*	❑ No ❑ Yes ❑ Not applicable for first dose *If yes, please provide details:* _____ ❑ I choose not to have my child receive the Pfizer−BioNTech COVID−19 vaccine at this time. ❑ I have read the information and wish my child to receive the next dose of Pfizer−BioNTech COVID−19 vaccine at this time despite the recommendation to defer the next dose.
Does your child have a history of myocarditis or pericarditis and are they still being followed by a physician for related heart issues?	❑ No ❑ Yes *If yes, you should follow up with your child's provider before they receive the vaccine.*
Has your child already received COVID−19 vaccines outside of Nova Scotia?	❑ No ❑ Yes *Please provide details:* _____ *Let the immunization provider know that your child has already received some of these vaccines while they have lived in another province / country.*
If this is your child's second dose of Pfizer−BioNTech COVID−19 vaccine, did they experience any serious side effects after the first dose?	❑ No ❑ Yes ❑ Not applicable *If yes, please provide details:*
Does your child have problems with their immune system or are they taking any medications that can affect their immune system (i.e. high dose steroids, chemotherapy)? *Immunocompromised people have received the Pfizer−BioNTech COVID−19 mRNA vaccine during the pandemic. There have not been any unique safety concerns raised about negative health effects from COVID−19 vaccine for immunocompromised people.* *People who are immunocompromised may have a diminished or a delayed response to a COVID−19 vaccine.*	❑ No ❑ Yes

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Does your child have an autoimmune disease? *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−BioNTech COVID−19 vaccine during the pandemic.* *There have not been any unique safety concerns raised about negative health effects from vaccine for autoimmune individuals.*	❑ No ❑ Yes
Does your child have a bleeding disorder or are they taking medications that could affect blood clotting?	❑ No ❑ Yes
Has your child ever felt faint after a past vaccination or medical procedure?	❑ No ❑ Yes
Has your child 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)
Has your child received another vaccine (not a COVID−19 vaccine) within 14 days of their vaccine appointment? *As a precaution, the National Advisory Committee on Immunization (NACI) recommends that COVID−19 vaccines should not routinely be given at the same time with other vaccines. There may be circumstances in which simultaneous administration, or a shortened interval may be warranted on an individual basis.* *A health care 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)

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Do you require assistance at your appointment for reduced mobility?	❑ No ❑ Yes

As a parent / guardian 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=91444

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

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

Signature: _____ Print Name: _____

Date: _____
(YYYY/MON/DD)

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The following questions are OPTIONAL and will not impact the services or care that your child receives. Please check the following that apply to your child.

Race / ethnicity: Which race category best describes your child?

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

Do you identify as Indigenous?

❑ Prefer not to answer ❑ Yes ❑ No ❑ Unknown

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

Does your child 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: ❑ First ❑ Second

VACCINE Dose # _____	**DOSE**	**LOT NUMBER**	**EXPIRY DATE** (YYYY/MON/DD)	**SITE and ROUTE**	**TIME GIVEN**	**DATE GIVEN** (YYYY/MON/DD)	**GIVEN BY Name and Designation**
Pfizer−BioNTech Comirnaty COVID−19 Vaccine (COVID−19 mRNA Vaccine)	**0.2 mL**						

Comments:

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