COVID-19 Vaccination Patient Screening and Consent
mRNA COVID-19 Vaccines

(Version 4. 2024AUG07)

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: _____

Weight (if under 12 years): _____ Date weight obtained: _____ (YYYY/MON/DD)

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

Is the person listed on this form consenting for themselves? ❑ Yes ❑ No

If no: Name of parent/legal guardian or substitute decision maker: _____

Relationship to the person listed on this form: _____

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

Pre-Immunization Assessment (answer for the person listed on this form):	Yes	No
Is this your first COVID-19 vaccine? If no, please list the last vaccine you received and when: _____ (YYYY/MON/DD)		
Have you ever fainted following a previous vaccination?		
Have you ever had a serious reaction (including anaphylaxis) to any previous injection or vaccine(s) - including a COVID-19 vaccine? If yes, please describe:		
Are you moderately to severely immunocompromised? If yes, please provide details:		
Do you have any other medical conditions that place you at high risk for severe COVID-19 disease? If yes, please provide details:		
Do you have a history of multisystem inflammatory syndrome in children (MIS-C) or adults (MIS-A)? If yes, are you considered recovered? ❑ Yes ❑ No If recovered, has it been at least 90 days since diagnosis? ❑ Yes ❑ No		
Have you ever developed Guillain-Barre Syndrome? If yes, please provide date and details: _____ (YYYY/MON/DD)		
Have you developed myocarditis or pericarditis following a COVID-19 vaccination? If yes, please provide date and details: _____ (YYYY/MON/DD)		
Do you have a history of myocarditis or pericarditis unrelated to COVID-19 vaccination? If yes, please provide date and details: _____ (YYYY/MON/DD)		

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	Yes	No
Did you experience thrombosis with thrombocytopenia syndrome or vaccine-induced thrombotic thrombocytopenia following a previous dose of COVID-19 vaccine? If yes, you should talk with your health care provider before you receive the COVID-19 vaccine.		
Have you received monoclonal antibodies? If yes, please list what you received and when: _____ (YYYY/MON/DD)		
Do you have an allergy to any of the following? ❑ Polyethylene glycol (PEG) ❑ Tromethamine (trometamol or TRIS) ❑ Polysorbate 80 If yes, check all that apply and talk to your health care provider before receiving the COVID-19 vaccine.		
Have you had a COVID-19 infection in the last 6 months? If yes, please provide date of symptom onset/positive test (if no symptoms): _____ (YYYY/MON/DD)		
Do you have a bleeding condition or use any blood thinners (ex. Warfarin, low or high dose aspirin)?		
Are you pregnant?		
Have you ever had a mastectomy with lymph node removal?		

- I have reviewed the COVID-19 information sheet:
  - ❑ mRNA COVID-19 Vaccine Information Sheet
- I understand the benefits, side effects, risks (including risks of not receiving vaccine) associated with the COVID-19 vaccine.
- I agree that I/the person listed on this form will remain at the pharmacy for at least 15-30 minutes following administration of the medications/vaccine or as directed by the pharmacist.
- I authorize the immunizer to administer epinephrine and/or life-saving procedures to myself/the person on this form in the event of a severe allergic reaction and to notify the emergency contact person.
- I authorize the immunizer to notify my/the person listed on this form's physician/nurse practitioner and/or public health the vaccine received and to contact me with any follow-up if needed.

Please select one:

❑ **I consent for myself/the person listed on this form to receive the COVID-19 vaccine.**

❑ **I have questions for the immunizer before I/the person listed on this form receive(s) the COVID-19 vaccine.**

❑ **I do not consent for myself/the person listed on this form to receive the COVID-19 vaccine.**

Name (print): _____ **Signature:** _____
(Guardian/agent as required)

Date (YYYY/MON/DD): _____

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IMMUNIZER USE ONLY

INJECTION ADMINISTRATION DOCUMENTATION:

Vaccine Dose: _____

Product		**Dose**	
Lot		**Expiry**	
Site and Route	_____ _____	**Date and Time Administered**	_____ (YYYY/MON/DD) _____ (HH:MM)

PATIENT MONITORING AND FOLLOW UP

15-30 minutes post injection: ❑ Patient appears fine, no adverse reaction(s)

Comments: _____

Immunizer Name and Designation	
Immunizer Signature	