nova scotia health | IWK Health

COVID-19 Vaccination Patient Screening and Consent

Janssen COVID-19 Vaccine

(Version 1. 2023MAR02)

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.

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

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)

❑ Contract Worker - Specify: ____________________

❑ Learner/Student Specify School: ____________________ Program: ____________________ Year (1st, 2nd, etc.): ______

❑ Volunteer ❑ Other: ____________________

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?		

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	Yes	No
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)		
Did you experience thrombosis with thrombocytopenia syndrome or vaccine-induced thrombotic thrombocytopenia following a previous dose of Janssen or AstraZeneca COVID-19 vaccine? If yes, you should not receive Janssen COVID-19 vaccine.		
Do you have a history of thrombosis with thrombocytopenia not related to previous COVID-19 vaccination? If yes, you should talk with your health care provider before receiving the Janssen COVID-19 vaccine.		
Do you have a history of capillary leak syndrome? If yes, you should not receive Janssen COVID-19 vaccine.		
Do you have a history of immune thrombocytopenia? If yes, you should talk to your health care provider before receiving the Janssen COVID-19 vaccine.		
Do you have a history of venous thromboembolism? If yes, you should talk to your health care provider before receiving the Janssen 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 Polysorbate 80? If yes, you should talk to your health care provider before receiving the Janssen 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? If yes, you should talk to your health care provider before receiving the Janssen COVID-19 vaccine.		
Have you ever had a mastectomy with lymph node removal?		

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- I have reviewed the COVID-19 information sheet relevant to the vaccine I will receive:
  - ❑ mRNA COVID-19 Vaccine Information Sheet
  - ❑ Novavax COVID-19 Vaccine Information Sheet
  - ❑ Janssen 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 will receive.
- 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 pracititioner 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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Answering the following OPTIONAL questions will help us understand the populations receiving the COVID-19 vaccine. They will not impact the services or care that you receive.

Demographic Information

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.

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)?**

   ❑ No ❑ Yes ❑ Unknown ❑ Prefer not to answer

2. **Do you live in a group living setting, such as a long-term care facility, group home, or shelter?**

   ❑ No ❑ Yes ❑ Unknown ❑ 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.

   ❑ 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.

   ❑ 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: ________________________________
   ❑ Prefer not to answer

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

   ❑ No ❑ Yes ❑ Unknown ❑ Prefer not to answer

   If yes, indicate which Indigenous identity:

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

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

   ❑ No ❑ Yes ❑ Unknown ❑ Prefer not to answer

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IMMUNIZER USE ONLY

INJECTION ADMINISTRATION DOCUMENTATION:

Vaccine Dose: ❑ Primary series dose #: ________ ❑ Booster dose

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

NOTES:

____
____
____
____
____

Immunizer Name and Designation	
Immunizer Signature	