COVID-19 VACCINE CONSENT FORM: FOR CHILDREN 5-11 YEARS OLD

Step 1. Child's Information

Child's Last Name				Child's First Name	
Child's Date of Birth Year	Month	Day	Age	☐ Female ☐ Male ☐ Self-identify ☐ Prefer not to answer	Child's Preferred Language
Child's Health Card # *(or alternative identifier if no health card)*				Child's Primary Care Clinician (Family physician, Pediatrician or Nurse Practitioner)	
Child's Home Address				Postal Code	Name of School or Child Care Centre
Does the child identify as Indigenous (First Nations, Métis, Inuit/Inuk)? ☐ Yes ☐ No ☐ Prefer not to answer					

Step 2. Child's Health History

Explain any "yes" answers

Has the child been sick in the past few days? Do they have symptoms of COVID-19 or have a fever today?	◎ Yes ◎ No	
Has the child received another vaccine in the last 14 days?	◎ Yes ◎ No	
Has the child ever been diagnosed with myocarditis or pericarditis?	◎ Yes ◎ No	
Does the child have today, or has the child recently had any new/unexplained shortness of breath or chest pain?	◎ Yes ◎ No	
Has the child had a previous history of multisystem inflammatory syndrome in children (MIS-C) unrelated to any previous COVID-19 vaccination?	◎ Yes ◎ No	
Has the child had a serious allergic reaction within 4 hours of a previous dose of the COVID-19 vaccine?	◎ Yes ◎ No	
Has the child previously had an allergic reaction to any vaccine or medication given by injection (e.g. IV,IM) needing medical care?	◎ Yes ◎ No	
Is the child allergic to tromethamine, polyethylene glycol, or polysorbate?	◎ Yes ◎ No	
Does the child have any problems with their immune system or are they taking any medications that can affect their immune system *(e.g. high dose steroids, chemotherapy)*? **If yes, are they receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies or other targeted agents?**	◎ Yes ◎ No ◎ Yes ◎ No	
Does the child have a bleeding disorder or are they taking any medications that could affect blood clotting (e.g. blood thinners)?	◎ Yes ◎ No	
Has the child ever fainted or felt faint after a past vaccination or medical procedure?	◎ Yes ◎ No	

Patient First and Last Name _____
Health Card # _____

Step 3. Consent for Vaccination and Collection, Use and Disclosure of Personal Health Information

My name is _____ and I am the substitute decision maker (e.g. parent or legal guardian) for this child.

I have been given the opportunity to review information about this vaccine, I have had an opportunity to ask questions and my questions have been answered to my satisfaction. I consent to this child receiving all recommended doses of the COVID-19 vaccine series, in accordance with the Ministry of Health's guidelines. I understand that I may withdraw consent at any time.

The personal health information collected on this form is being used to obtain consent for this child to receive the COVID-19 vaccines and to ensure it is safe for the child to be given the vaccines. This information will be disclosed to the Chief Medical Officer of Health and Ontario Public Health Units for public health administration reasons, and you consent to the electronic collection and transmission of this information. You can refuse to provide information on this form, but the COVID-19 vaccines may not be given without all required information. If you have any questions about the collection of the child's personal health information, please call 311 or send an email to *accesshalton@halton.ca*.

A hospital, local public health unit, or the Ministry of Health may wish to communicate with you for purposes related to the COVID-19 vaccine.

I consent to receiving communications by: ☐ Email
For the purpose of: ☐ Follow-up communications (e.g. record of vaccination) ☐ Research projects

Signature: _____ Date of Signature: _____

TO BE FILLED OUT BY /PARENTS/LEGAL GUARDIANS / SUBSTITUTE DECISION MAKERS

Your relationship to the child listed in step 1 _____

Your email address: _____ **Your phone number:** _____

I confirm that I am the: ☐ parent/legal guardian ☐ substitute decision maker

TO BE FILLED OUT BY CLINIC STAFF FOR VERBAL CONSENT

Verbal consent received from _____ ☐ parent/legal guardian ☐ substitute decision maker
Name of person providing consent

Consent given on _____ at _____
Date of consent time of consent

_____ _____ _____
Staff signature Staff Name Staff Designation

Once this form has been completed and signed, please bring it to the child's vaccination appointment. If you are unable to print the completed and signed form, clinic staff will provide you with an email address that the completed consent form can be emailed to. To be considered complete and valid, electronic consent forms must include an electronic signature. If you choose to email the form to us, you acknowledge that there are risks associated with email communications, and no email is guaranteed to be 100% secure.

Although this website is verified to be secure and the security of it will be regularly checked, some risks can exist when providing personal health information over the Internet. For further details about the security of our website, visit https://www.halton.ca/Privacy