mRNA COVID-19 VACCINE CONSENT FORM: 12+ years of age

(Please only complete this form if the client is not able to provide informed consent to receive the vaccines and requires a parent / legal guardian / substitute decision maker to provide informed consent on their behalf. If the client's parent / legal guardian / substitute decision maker will be accompanying the client to the appointment, this form is not required.)

Step 1. Client Information

Client's Last Name				Client's First Name	
Date of Birth Year:	Month:	Day:	Age:	☐ Male ☐ Female ☐ Self-identify ☐ Prefer not to answer	Preferred Language
Health Card # *(or alternative identifier)*			Home Phone		Cell Phone
Address					Postal Code
Name of Facility (if applicable)			Primary Care Clinician		Email

Do you identify as Indigenous (First Nations, Métis, Inuit/Inuk)? ☐ Yes ☐ No ☐ Prefer not to answer

Previous doses of a COVID-19 vaccine (please complete the information below for any dose(s) of vaccine previously received)

Dose #	Date Dose Administered:	Vaccine Name (e.g. Pfizer, Moderna):

Step 2. Client Health History

Explain any "yes" answers

1. Have you been sick in the past few days? Do you have symptoms of COVID-19 or have a fever today?	○ Yes ○ No	
2. Have you ever been diagnosed with myocarditis or pericarditis following any dose of an mRNA COVID-19 vaccine?	○ Yes ○ No	
3. Do you have any new / unexplained shortness of breath or chest pain?	○ Yes ○ No	
4. Have you had a serious allergic reaction within 4 hours to the COVID-19 vaccine before?	○ Yes ○ No	
5. Have you previously had an allergic reaction to any vaccine (including your first COVID vaccination if applicable) or medication given by injection (e.g. IV,IM), needing medical care?	○ Yes ○ No	
6. Are you allergic to tromethamine, polyethylene glycol, or polysorbate?	○ Yes ○ No	
7. Do you have any problems with your immune system or are you taking any medications that can affect your immune system *(e.g. high dose steroids, chemotherapy?).* **If yes:** 8. Are you receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies or other targeted agents?	○ Yes ○ No ○ Yes ○ No	
9. Do you have a bleeding disorder or are you taking any medications that could affect blood clotting (e.g. blood thinners)?	○ Yes ○ No	
10. Have you ever fainted or felt faint after a past vaccination or medical procedure?	○ Yes ○ No	

Client First and Last Name _____

Health Card # _____

Step 3. Consent for Vaccination

My name is _____ and I am the parent / legal guardian / substitute decision maker for this client.

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 client 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 client to receive the COVID-19 vaccines and to ensure it is safe for the client 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 client'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 SUBSTITUTE DECISION MAKERS/PARENTS/LEGAL GUARDIANS

If signing for someone other than yourself, indicate: Your relationship to the client listed in step 1. _____

Your email address: _____ Your phone number: _____

If signing for someone other than myself, 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

_____ _____
Email address of person providing consent Phone number 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 complete and signed, please bring it to the client's vaccine 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