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

Step 1. Client Information

Client's Last Name				Client's First Name	
Date of Birth Year:	Month:	Day:	Age:	◯Female ◯Male ◯Non-binary/third gender ◯Prefer not to answer ◯Other	Preferred Language
Health Card # *(or alternative identifier)*			Phone Number		
Address				Postal Code	
Name of Facility or School (if applicable)			Primary Care Clinician	Email	

Do you identify as one of the following:

◯First Nations
◯Métis
◯Inuit/Inuk

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

Dose #	**Date Dose Administered (YYYY/MM/DD):**	**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. Have you had a previous history of multisystem inflammatory syndrome unrelated to any previous COVID-19 vaccination?	○ Yes ○ No	
4. Do you have any new / unexplained shortness of breath or chest pain?	○ Yes ○ No	
5. Have you had a serious allergic reaction within 4 hours to the COVID-19 vaccine before?	○ Yes ○ No	
6. 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	
7. Are you allergic to tromethamine, polyethylene glycol, or polysorbate?	○ Yes ○ No	
8. 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:** 9. Are you receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies or other targeted agents?	○ Yes ○ No ○ Yes ○ No	
10. Do you have a bleeding disorder or are you taking any medications that could affect blood clotting (e.g. blood thinners)?	○ Yes ○ No	
11. 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

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 receiving the vaccine, including all recommended doses in the series in accordance with the Ministry of Health's guidelines.** I understand that I may withdraw my consent at any time.

The personal health information collected on this form is being used to obtain your consent to receive the COVID-19 vaccines. Your information will be used to make sure it is safe to give the vaccines. Your information will be disclosed to the Chief Medical Officer of Health, Ontario Public Health Units and Ontario hospitals for public health administration reasons and you consent to any electronic collection or transmission of your information. You can refuse to provide information on this form but the COVID-19 vaccines may not be given without all information. You acknowledge there is no guarantee that you will receive any particular brand of vaccine. 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.

Ontario hospitals, local public health units and the Ministry of Health may wish to communicate with you for the purposes related to the COVID-19 vaccine.

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

NOTE: We follow our internal protocols for privacy and security; however, risks may still exist with electronic communications. If consent for email and/or sms/text communications is provided, you may withdraw your consent to these forms of communication at any time in writing.

Signature: _____ Date of Signature: _____

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

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

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

Please complete and sign the form before the vaccine appointment. Please note that you are only required to complete and sign this form for clients who cannot provide their own informed consent in order to receive the vaccines and as such, require a parent / legal guardian / substitute decision maker to provide informed consent on their behalf.

Once this form has been completed and signed, it must be brought 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, the emailed consent form 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.

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

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 Halton's privacy practices and the security of our website, visit https://www.halton.ca/Privacy