COVID-19 CONSENT
FOR IMMUNIZATION (VAXZEVRIA/COVISHIELD)

VACCINE GIVEN: _____
DATE: _____
DOSE __ of __ (write 1 of 1 if not part of a series)

❶ CLIENT INFORMATION Complete Sections 1, 2, and 3 (please print)

Last Name:	First Name:	Date of Birth (YYYY/MM/DD):
Address:	Telephone Number:	
Emergency Contact and Relation:	Emergency Telephone Number:	
Personal Health Number:	Sex: ☐ Female ☐ Male ☐ Prefer not to say	

❷ SCREENING QUESTIONS

Contraindications	
1. Do you have any allergies?	No ☐ Yes ☐
1a. If yes: Do you have a severe allergy to: • **Polysorbate 80** – contained in the VAXZEVRIA/COVISHIELD and Janssen vaccines. It is also found in medical preparations (e.g., vitamin oils, tablets and anticancer agents) and cosmetics.	No ☐ Yes ☐ *If yes, please provide details:*
1b. If yes to #1, have you had severe allergic reaction (anaphylaxis) from an unknown cause? Were you seen by an allergy specialist?	No ☐ Yes ☐ *If anaphylaxis without known or obvious cause, consider referral to an allergist prior to immunization.*
2. If this is your second COVID-19 vaccine dose, did you have any of the following after the first dose? • A severe allergic reaction (e.g., anaphylaxis) • Thrombosis with thrombocytopenia following a previous dose of an adenovirus vector COVID-19 vaccine.	No ☐ Yes ☐
3. Do you have a history of capillary leak syndrome?	No ☐ Yes ☐ *If yes, the individual should be offered an mRNA COVID-19 vaccine*.
Precautions	
4. If this is your second dose, did you have any allergic reactions after the first dose, or side effects for which you sought medical attention?	No ☐ Yes ☐ *If yes, please provide details:*
5. Have you ever experienced a previous cerebral venous sinus thrombosis (CVST) with thrombocytopenia or heparin-induced thrombocytopenia (HIT)?	No ☐ Yes ☐ *If yes, the individual should only receive an adenovirus vector COVID-19 vaccine if the benefits outweigh the potential risks, and an mRNA vaccine is unavailable.*
6. Have you recently received specific medications for COVID-19 prevention or treatment (monoclonal antibodies or convalescent plasma) within the last 3 months?	No ☐ Yes ☐ *If yes, defer vaccination for at least 90 days following receipt of these antibody treatments. Deferral is not required following treatment with tocilizumab or sarilumab.*
7. Have you been diagnosed with Multisystem Inflammatory Syndrome in Children (MIS-C) or Adults (MIS-A) within the last 3 months?	No ☐ Yes ☐ *If yes, defer vaccination for at least 90 days following date of MIS-C or MIS-A diagnosis.*

Special Considerations	
8. Are you feeling ill today?	No ☐ Yes ☐ *If yes, what symptoms?*
9. Have you ever felt faint or fainted after a past vaccination or medical procedure?	No ☐ Yes ☐ *If yes, please provide details:*

❸ CONSENT

☐ Client ☐ Parent ☐ Legal Guardian ☐ Representative

☐ I understand that I will be asked at the appointment to provide consent for the vaccination.
☐ I will stay as directed by the pharmacist after the vaccination and seek medical attention if needed.
☐ I will report any adverse effects I experience to the immunizing pharmacist.

Name: (PRINT) _____ Phone: _____

Signature: _____ Date Signed (YYYY/MM/DD): _____

FOR PHARMACIST USE ONLY

☐ The patient was provided and understood information about the vaccine listed below. They understand the benefits and possible reactions to the vaccine and the risk of not getting immunized. They have beeninformed of any medical reason why the vaccine listed below should not be given to them/their child. They have had the opportunity to ask questions that were answered to their satisfaction. They gave their consent voluntarily and understand that this consent is valid for the vaccine listed below.

❹ VACCINE INFORMATION

Name of vaccine: _____ DIN: _____

Dose: _____mL Site: LA / RA Route: IM

Lot #: _____

Expiry date (YYYY/MM/DD): _____

LA left arm; RA right arm; IM intramuscular

Pharmacy Label

❺ PHARMACY INFORMATION

Pharmacist signature: _____ Licence number: _____

Date of administration (YYYY/MM/DD): _____ Time of administration: _____

❻ CLIENT RESPONSE

Before: Normal Yes ☐ No ☐ _____ **15-30 mins post-administration:** Normal Yes ☐ No ☐ _____

During: Normal Yes ☐ No ☐ _____ **Other comments:** _____