COVID-19 Vaccine All-In-One Backup Paper Record

CONSENT FORM –COVID-19 Vaccine (MOH 11March2021)

Last Name	First Name	Identification (e.g., health card #)
Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ Prefer not to answer ☐ Other: _____		Primary Care Clinician (Family Physician or Nurse Practitioner)
If Indigenous, please indicate which Indigenous identity: ☐ First Nations ☐ Métis (includes members of the Métis organization or Settlement) ☐ Inuk/ Inuit ☐ Other Indigenous, specify: _____ ☐ Prefer not to answer ☐ Unknown		
Home Phone	Mobile Phone	
Email Address		

Street Address	City	Province	Postal Code

Date of Birth (month,day, year)	Age	Is this your **first or second dose** of the vaccine? ☐ First ☐ Second If second, please indicate the date of your first dose and name ofvaccine administered: _____/_____/_____(month, day, year) Name of vaccine administered: _
_____/_____/_____		

Consent to Receive the Vaccine

I have read (or it has been read to me) and I understand the Immunization Prepackage, including the following documents: 'COVID-19 Vaccine Information Sheet' and 'What you need to know about your Covid-19 vaccine appointment'.

- I have had the opportunity to ask questions regarding the vaccine I am receiving and to have them answered to my satisfaction.

☐ **I consent to receiving the vaccine, including all recommended doses in the series.**

- I understand that I may withdraw this consent at any time.
- I understand that if I am withdrawing consent as a substitute decision maker of an individual, then I must contact the congregate setting that the individual resides in.

Note: Please contact the vaccination clinic where you are supposed to receive the Covid-19 vaccine if you change your mind and no longer consent to receiving the vaccine. This will allow someone else to take your spot. If consent has been withdrawn by a substitute decision maker of an individual who resides in a congregate setting, then the congregate setting must contact the local public health unit.

Acknowledgement of Collection, Use and Disclosure of Personal Health Information

The personal health information on this form is being collected for the purpose of providing care to you and creating an immunization record for you, and because it is necessary for the administration of Ontario's COVID-19 vaccination program. This information will be used and disclosed for these purposes, as well as other purposes authorized and required by law. For example,

- it will be disclosed to the Chief Medical Officer of Health and Ontario public health units where the disclosure is necessary for a purpose of the *Health Protection and Promotion Act*. And
- it may be disclosed, as part of your provincial electronic health record, to health care providers who are providing care to you.

The information will be stored in a health record system under the custody and control of the Ministry of Health.

Where a Clinic Site is administered by a hospital, the hospital will collect, use and disclose your information as an agent of the Ministry of Health.

□ **I acknowledge that I have read and understand the above statement.**

You may be contacted by a hospital, local public health unit, or the Ministry of Health for purposes related to the COVID-19 vaccine (for example, to remind you of follow up appointments and to provide you with a record of immunization). If you consent to receiving these follow up communications by email, please indicate this using the box below.

☐ **I consent to receiving follow-up communications:**

☐ **by email** ☐ **by text/SMS**

If selected by email, please provide your email address: _____

Consent to Being Contacted About Research Studies

You have the option of consenting to be contacted by researchers about participation in COVID-19 vaccine related research studies. If you consent to be contacted, your personal health information will be used to determine which studies may be relevant to you, and your name and contact information will be disclosed to researchers. Consenting to be contacted about research studies does not mean you have consented to participate in the research itself. Participating in research is voluntary. You may refuse to consent to be contacted about research studies without impacting your eligibility to receive the COVID-19 vaccine.

If you do not wish to be contacted about research studies, please indicate this below.

If you consent to be contacted about research studies, and then change your mind, you may withdraw consent at any time by contacting the Ministry of Health at vaccine@ontario.ca.

This will not impact your eligibility to receive the Covid-19 vaccine.

I consent to be contacted about COVID-19 vaccine related research studies:

☐ **by email** ☐ **by text/SMS** ☐ **by phone** ☐ **by mail**

If selected by email, please provide your email address: _____

☐ **I do not consent to be contacted about COVID-19 related research studies:**

Signature	Print Name	Date of Signature

If signing for someone other than yourself, indicate your relationship to that other person:

☐ If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker.

Specific Issues re: Long-Term Care Homes Act, 2007

The resident's consent to receive the vaccine may be withdrawn or revoked at any time.

Statement respecting section 83 of the Act:

Please note the following legal protection:

Every licensee of a long-term care home shall ensure that no person is told or led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because,

a) a document has not been signed;
b) an agreement has been voided; or
c) a consent or directive with respect to treatment or care has been given, not given, withdrawn or revoked.

Notes

Pre-Screening (MOH 21May2021 + 23June2021 AZ Update + COVax 30Jun2021)

Has the COVID-19 Vaccine Information Sheet for individuals who received a first dose of Astra Zeneca COVID-19 Vaccine/COVID-19 COVISHIELD been reviewed with the client as part of the pre-assessment? ☐ No ☐ Yes ☐ N/A (Client did not receive AZ/COVISHIELD for Dose 1)	
If the client is receiving the AstraZeneca/COVISHIELD or Janssen COVID-19 Vaccine: **Have you experienced major venous and/or arterial thrombosis with thrombocytopenia following vaccination withany vaccine?** ☐ No ☐ Yes	If yes, please provide details
Have you experienced a pervious cerebral venous sinus thrombosis (CVST) with thrombocytopenia or a heparin- induced thrombocytopenia (HIT)? ☐ No ☐ Yes	If yes, please provide details
Have you been sick in the past few days? Do you have symptoms of COVID-19 or have a fever today? ☐ No ☐ Yes	If yes, please provide details
Have you had a serious allergic reaction within 4 hours to theCOVID-19 vaccine before? ☐ No ☐ Yes	If yes, please provide details
Do you have allergies to polyethylene glycol, tromethamine(Moderna only) or polysorbate? ☐ No ☐ Yes	If yes, please provide details
Have you had a serious allergic reaction to a vaccine or medication given by injection (e.g., IV, IM), needing medical care? ☐ No ☐ Yes	If yes, please provide details
Have you received another vaccine (not a COVID-19 vaccine) in the past 14 days? ☐ No ☐ Yes	If yes, please provide details

Are you or could you be pregnant or breastfeeding? ☐ No ☐ Yes	
Do you have a weakened immune system or are you taking any medications that can weaken your immune system (e.g., high dose steroids, chemotherapy)? ☐ No ☐ Yes	If yes, please provide details
If yes, are you receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies or other targeted agents? ☐ No ☐ Yes **If on one of the therapies listed, have you spoken with your treating health care provider about getting the vaccine?** ☐ No ☐ Yes	If yes, please provide details
Do you have a bleeding disorder or are taking blood thinners? ☐ No ☐ Yes	If yes, please provide details
Have you ever felt faint or fainted after receiving a vaccine or medical procedure? ☐ No ☐ Yes	If yes, please provide details

Clinical Record – COVID-19 Vaccine (COVax 30Jun2021)

FOR CLINIC USE ONLY							
Agent	COVID-19	Product Name		Lot # & Expiry		Dose Amount:	
Anatomical Site	☐ Left deltoid ☐ Right deltoid			Route	Intramuscular (IM)	Dose #:	
Date Given	_____ /_____/ _____ (m/d/yyyy)			Time Given	____ :____ am pm	AEFI? (after receiving current dose)	☐ Yes ☐ No
Given By (Name, Designation)				Location		Authorized By	

Reason for Immunization	☐ Long Term Care: Resident ☐ Long Term Care: Healthcare Worker ☐ Long Term Care: Other Employee ☐ Long Term Care: Other Non-Employee ☐ Long Term Care: Essential Caregiver ☐ Retirement Home: Healthcare Worker ☐ Retirement Home: Resident ☐ Retirement Home: Essential Caregiver ☐ Retirement Home: Other Employee ☐ Retirement Home: Other Non-Employee ☐ ALC: Alternate Level of Care Patients in Hospitals ☐ Healthcare Worker ☐ Indigenous community ☐ Chronic Home Care ☐ Advanced Age: Community Dwelling ☐ Person with Priority Health Condition	☐ Caregiver of Person with Priority Health Condition ☐ Congregate Living: Resident ☐ Congregate Living: Staff ☐ Congregate Living: Essential Caregiver ☐ Agriculture: Temporary Foreign Worker-Congregate Setting ☐ Community at Greater Risk ☐ Agriculture or Farm Worker (not temp foreign worker) ☐ Food Manufacturing Worker ☐ Education Worker ☐ Child Care Worker ☐ Essential worker who cannot work from home ☐ Youth 12+ ☐ Age Eligible Population ☐ Other Priority Population

Reason Immunization NotGiven	☐ Immunization is contraindicated ☐ Practitioner recommends immunization but no PATIENT consent ☐ Practitioner decision to temporarily defer immunization ☐ Medically Ineligible ☐ Patient withdrew consent for series