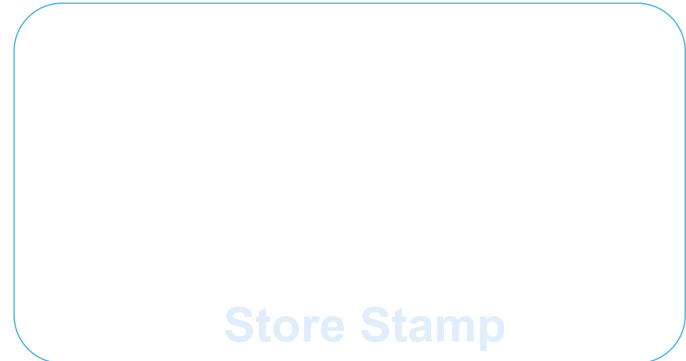
COVID-19 VACCINE ADMINISTRATION SCREENING AND CONSENT FORM

Please complete this form and read the supplemental information provided by the Pharmacist before receiving ______________________________ (name of COVID-19 vaccine). Your answers to these questions will help the Pharmacist determine if the COVID-19 vaccine is appropriate at this time. If you are a legal representative providing consent for another person, please complete this information for the person who will be receiving the COVID-19 vaccination.

PATIENT INFORMATION

Legal First and Last Name:		
Age:	Date of Birth: _______ / _______ / _______ (yyyy / mm / dd)	*(collected for clinical assessment & reimbursement)* Sex: ❑ Male ❑ Female ❑ _____________ (self-identify)
Address: Street, Apartment, City, Province, Postal Code		
Health Card #: (Personal Health Identification Number)	Telephone:	
Emergency Contact Name and Phone Number:		

If you have questions and/or concerns about this form or the COVID-19 vaccine, please speak with the Pharmacist at:



Screening Questionnaire for Person Receiving COVID-19 Vaccine

Screening Questionnaire for Person Receiving COVID-19 Vaccine	Yes	No
Have you been sick in the past few days? Do you have symptoms of COVID-19 or have a fever today?		
Have you received any previous COVID-19 vaccine(s)? If yes, when was your last dose (YYYY/MM/DD): ___________________________		
Have you experienced serious side effects from a previous dose(s)?		
In the last 6 months, have you previously tested positive for a COVID-19 infection?		
In the last 3 months, have you previously been admitted to the hospital due to a COVID-19 infection and treated with convalescent plasma or monoclonal antibodies (received treatment intravenously [by IV])?		
Do you have a history of: • heparin-induced thrombocytopenia (HIT) or • thrombosis associated with lupus anticoagulant (thrombotic antiphospholipid syndrome) or • capillary leak syndrome or • cerebral venous sinus thrombosis (CVST) with thrombocytopenia or • multisystem inflammatory syndrome in children (MIS-C) or • venous or arterial thrombosis with thrombocytopenia following a viral vector vaccine (e.g., AstraZeneca, COVISHIELD vaccines) • myocarditis or pericarditis following the first dose of mRNA COVID-19 vaccine (e.g., Pfizer, Moderna)		
Do you require a tuberculin skin testing (TST) or interferon gamma release assay (IGRA) test within the next 4 weeks?		
Have you had a known, or suspected allergy, or a severe anaphylactic allergic reaction (e.g. difficulties breathing, itchy/swelling of mouth or throat, hives) to: • Polyethylene glycol (PEG) can be found in some products such as cosmetics, skin care products, cough syrups and laxatives); or • Polysorbate 80 (Polysorbate 80 may be found in medical preparations (such as vitamin oils, tablets, and anticancer agents), and cosmetics); or • Tromethamine (tromethamol or Tris) (Tromethamine may be found in contrast media and medications taken orally or by injection) or • Any component of any of the COVID-19 vaccines?		
Have you had severe or anaphylactic reaction to another vaccine in the past? (e.g. difficulties breathing, itchy/swelling of mouth or throat, hives)		
Are you pregnant or planning to become pregnant? Are you nursing or breastfeeding?		
Are you taking any medications that can weaken your immune system? (e.g. high dose steroids, anticancer or transplant medications?)		
Do you have an autoimmune condition (e.g. rheumatoid arthritis, multiple sclerosis, Crohn's disease, lupus)?		
Do you have any medical conditions that require regular visits to a primary care provider (e.g., doctor)?		
Do you have a bleeding disorder or are you taking medications that can affect blood clotting (eg., blood thinner including: Aspirin, warfarin, Eliquis®, Lixiana®, Pradaxa®, Xarelto®)		
Have you ever felt faint or fainted after receiving a vaccine or medical procedure?		
Have you received any other vaccine in the past 14 days?		
If you answered yes to any of the questions above, please describe:		

COVID-19 Vaccine Administration

I consent to have the Health Care Professional (HCP) administer the COVID-19 vaccine to the individual named above. I agree to ask the Pharmacist any questions I may have about the COVID-19 vaccine or vaccine administration prior to receiving the vaccination. I have reviewed the COVID-19 vaccine information provided to me. I understand the risks, benefits, expected outcome and possible side effects of this vaccine and agree to wait in the pharmacy for at minimum 15 minutes after receiving the vaccination. I agree that the pharmacy may share my personal health information regarding this vaccination as required with public health officials and other healthcare providers.

❑ I am providing consent for myself

❑ I am providing consent for the patient identified above.

If providing consent for patient identified above, complete below:

Contact information of patient agent (name and telephone): _________________________________
____

Relationship to person receiving this COVID-19 vaccination:

❑ *Parent* ❑ *Guardian* ❑ *Other, please specify* ______________________

Name of person providing consent: ____________________________________

Signature of person providing consent: ____________________________

Date: ________ / ________ / ________ (yyyy / mm / dd)

Pharmacy Use Only – COVID-19 VACCINE

COVID-19 Vaccine Product: Manufacturer: DIN:	Date of administration (yyyy/mm/dd): Time of administration: ____________ AM/PM
Lot number: Expiry Date (yyyy/mm/dd): Dose in mL:	Route and site of administration: Intramuscular (IM) Deltoid: ❑ Right ❑ Left Other: ________________ Primary series ❑ First ❑ Second ❑ Third (if applicable) Booster series ❑
Rationale for COVID-19 Vaccination administered Indicated for active immunization against coronavirus disease 2019 (COVID-19) caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus	
Patient counseling	❑ Potential adverse reactions and their management ❑ Reinforce the importance of adhering to vaccine schedule If applicable: ❑ Pregnancy ❑ Breastfeeding ❑ Autoimmune condition ❑ Immunosuppressed ❑ Other Comments: ____
Patient response Adverse reaction: ❑ Yes ❑ No	If yes, describe nature of the reaction and action(s) taken after 15 minutes? ____
Follow-up	❑ Yes ❑ No *(If yes, describe the reason for follow-up and timing)* ____

I confirm that the patient named in this document is capable of, and has provided consent to, receive this COVID-19 vaccine indicated in this document, or that a parent/guardian or other agent has provided consent on behalf of the patient. I confirm that this COVID-19 vaccine should be given to the patient based on my assessment. I confirm that the patient/agent has provided informed consent.

Name and Designation of Health Care Professional (HCP) administering vaccine:____

HCP License Number:___________________________________ HCP Signature: ____

Updated: January 2023

Patient COVID-19 Vaccine Administration Record

AFFIX LABEL OF ADMINISTERED DRUG

COVID-19 VACCINATION

If applicable, your next appointment is: ____________________

Time of administration: ____________ AM / PM

Dose administered: __________

Route of administration: Intramuscular (IM)

Site of administration: Deltoid: ☐ Right ☐ Left Other ________

Lot # _________ Expiry: ____________

Keep this record in a safe place with your other personal medical information.