WHOLEHEALTH PHARMACY PARTNERS

COVID-19 Vaccine Screening & Consent Form

Last Name	First Name		Identification (e.g., health card number)	
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 the first dose and name ofvaccine administered: ...../...../.....(month, day, year) Name of vaccine administered: _____		

Please answer all the questions below:	
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 or a reaction within 4 hours to the COVID-19 vaccine before? ☐ No ☐ Yes	If yes, please provide details
Do you have allergies to polyethylene glycol [PEG], 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 a vaccine in the past 14 days? ☐ No ☐ Yes	If yes, please provide details
Are you or could you be pregnant or breastfeeding? ☐ No ☐ Yes If **pregnant**, have you spoken with your treating health care provider about getting the vaccine? ☐ No ☐ Yes	If yes, please provide details
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, **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 an autoimmune condition? ☐ No ☐ Yes	If yes, please provide details

Do you have a bleeding disorder or are taking blood thinning? ☐ 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
* Symptoms of COVID-19 can include fever, new onset of cough or worsening of chronic cough, shortness of breath, difficulty breathing, sore throat, difficulty swallowing, decrease or loss of smell or taste, chills, headaches, unexplained tiredness / malaise / muscle aches, nausea / vomiting, diarrhea or abdominal pain, pink eye, or runny nose or nasal congestion without other known cause or, for those over 70 years of age,,an unexplained or increased number of falls, acute functional decline, worsening of chronic conditions or delirium.	**Polyethylene glycol (PEG) can rarely cause allergic reactions and is found in products such as medications, bowel preparation products for colonoscopy, laxatives, cough syrups, cosmetics, skin creams, medical products used on the skin and during operations, toothpaste, contact lenses and contact lens solution. PEG also can be found in foods or drinks, but is not known to cause allergic reactions from foods or drinks. Polysorbate may also cause allergic reactions because of crossreactivity with PEG.

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-19vaccine 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.

Signature of patient/agent	Print Name of patient/agent	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.

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Agent	COVID-19	Product Name	Covishield	Lot #		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)			Pharmacy address			Immunizer signature	
Reason for Immunization	☐ Healthcare Worker ☐ LTC: Resident ☐ LTC: Healthcare Worker ☐ LTC: Other Non- Employee ☐ RH: Healthcare Worker ☐ RH: Resident ☐ RH: Essential Caregiver ☐ RH: Other Non-Employee ☐ Advanced Age: Community Dwelling ☐ Adult of Chronic Health Care ☐ Indigenous community ☐ Other Priority Population ☐ Congregate Living: Resident ☐ Congregate Living: Staff ☐ Congregate Living: Essential Caregiver						
Reason Immunization Not Given	☐ Immunization is contraindicated ☐ Practitioner recommends immunization but no PATIENT consent ☐ Practitioner decision to temporarily defer immunization ☐ Medically Ineligible ☐ Patient withdrew consent for series						
Your dose 2 of 2 is scheduled for:	...../...../.....(month, day, year) _____ :____am pm						