COVID-19 VACCINE SCREENING & CONSENT

York Region

Clinic Location/Facility Name: Today's Date (yyyy/mm/dd):

CLIENT INFORMATION

First Name:				Last Name:	
Date of Birth:	Year	Month	Day	Age	☐ Male ☐ Female ☐ Other
Health Card #				Email:	
Address:				Postal Code:	Primary Phone:

SCREENING QUESTIONS

Have you been diagnosed with myocarditis or pericarditis following a previous dose of an mRNA COVID-19 vaccine? The next dose in the mRNA vaccine series should be deferred in clients who experience myocarditis or pericarditis following a previous dose of the mRNA COVID-19 vaccine.	☐ Yes ☐ No
Have you ever had myocarditis or pericarditis before?	☐ Yes ☐ No
Do you have (or have you recently had) any shortness of breath or chest pain?	☐ Yes ☐ No
Have you had a previous COVID-19 infection? If yes, when? *Previous infection is defined as (i) a molecular (e.g., PCR) or Rapid Antigen Test); or (ii) symptomatic AND a household contact of a confirmed COVID-19 case*	☐ Yes ☐ No
Have you been sick in the past few days? Do you have symptoms of COVID-19 or have a fever today?	☐ Yes ☐ No
Have you had a serious allergic reaction within 4 hours to the COVID19 vaccine before?	☐ Yes ☐ No
Do you have allergies to polyethylene glycol, tromethamine (Moderna/Pediatric Pfizer only) or polysorbate or any components of the vaccine?	☐ Yes ☐ No
Have you had a serious allergic reaction to a vaccine or medication given by an injection (e.g., IV, IM), needing medical care?	☐ Yes ☐ No
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)? *If yes, are you receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies, or other targeted agents?*	☐ Yes ☐ No
Do you have a bleeding disorder or are taking blood thinners?	☐ Yes ☐ No
Have you ever felt faint or fainted after receiving a vaccine or medical procedure?	☐ Yes ☐ No
Are you actively receiving monoclonal antibody therapy OR convalescent plasma therapy for the treatment or prevention of COVID-19? *If yes, COVID-19 vaccine should not be given during therapy/treatment*	☐ Yes ☐ No

ADDITIONAL QUESTIONS FOR ALL CLIENTS 6 MONTHS TO 11 YEARS OLD ONLY

Do you have previous history of multisystem inflammatory syndrome in children (MIS-C), unrelated to any previous COVID-19 vaccination? (If yes, vaccination should be postponed until clinical recovery has been achieved or until it has been ≥90 days since diagnosis, whichever is longer).	☐ Yes ☐ No
Have you received another vaccine (not a COVID-19 vaccine) in the past 14 days?	☐ Yes ☐ No
Please review any questions with your Immunizer, prior to vaccination	
Have you had a previous dose of COVID-19 Vaccine? If yes, Dose 1 date (yyyy/mm/dd) _____ Product Name: _____ Dose 2 date (yyyy/mm/dd) _____ Product Name: _____ Dose 3 date (yyyy/mm/dd) _____ Product Name: _____ Dose 4 date (yyyy/mm/dd) _____ Product Name: _____ Dose 5 date (yyyy/mm/dd) _____ Product Name: _____	☐ Yes ☐ No

CONSENT & COLLECTION OF INFORMATION

I have read The Regional Municipality of York's COVID-19 Vaccine Information Sheet, or it has been read to me. I understand the benefits and possible side effects of the vaccine and that certain persons listed on the Information Sheet should not get the COVID-19 vaccine. I have had an opportunity to have my questions answered from a representative of the clinic location/facility.

☐ ***I consent to receiving the COVID-19 vaccine, including all recommended doses in the series***
☐ **I understand that I may withdraw this consent at any time**

FOR CLIENTS LIVING IN CONGREGATE CARE SETTINGS (example: long-term care homes and retirement homes) I understand that if I am withdrawing consent as a substitute decision maker (SDM) of an individual, then I must contact the congregate care setting that the individual resides in.

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*. It may also 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.

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

You may be contacted for purposes related to the COVID-19 vaccine (for example, to remind you of follow up appointments and to provide you with proof of vaccination).

☐ ***I consent to receiving follow-up communications by email or by text/SMS***

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

☐***I consent to be contacted about COVID-19 vaccine related research studies:***
☐ ***by email*** ☐ ***by text/SMS*** ☐ ***by phone*** ☐ ***by mail***
☐ ***I do not consent to be contacted about COVID-19 related research studies***

Client or SDM Signature:

If applicable: Parent/Legal Guardian/SDM **Full Name:** **Contact Phone #:**	**Date signed** (yyyy/mm/dd)**:**

For Clinic Use Only: Complete this section if vaccine administration is not entered into COVAX

Client Full Name:	**If applicable: Parent/Legal Guardian/SDM Signature:**	**Date Signed:**
COVID-19 Product Name:		
Diluent Lot # ☐N/A		**Client DOB:**
Route and Anatomical Site: ☐IM – Right Deltoid ☐IM – Left Deltoid ☐IM – Right Anterolateral thigh ☐IM – Left Anterolateral thigh		**Lot #**
Date given (yyyy/mm/dd):	**Dose volume:**	
Dose Number:		
Reason for Immunization: ☐Child/Youth 5+ ☐Infant/Child 6 months – 4 years	**Time given:** **AEFI after receiving current dose?** ☐Yes ☐No	
Reason for Paper Documentation:		
☐ No consent for COVax entry	☐Age priority population – Age eligible population	Other reason: _____
Immunizer Full Name and Designation:		
Immunizer Signature:	☐ COVax unavailable	☐ Other:

Complete below if immunization not given

Reason immunization not given:

☐ Immunization is contraindicated
☐ HCP decision to temporarily defer immunization
☐ Medically ineligible
☐ Client withdrew consent
☐ HCP recommends immunization but no client consent
☐ Below minimum monograph age

For ACI/office use only to document post-clinic data entry into COVax as appropriate	Date/time entered **(office use only)**	Printed Name **(office use only)**