Consent for COVID-19 vaccines

Clear Form

Section 1 Personal Information

13125 (2021/03/11)

Last name	First name	Medicare number

Home phone	Mobile phone	Email	Clinic location / Site information

Street address	City	Province	Postal code

D.O.B (YYYY/MM/DD)	Gender	Is this your first or second dose of the vaccine?
	☐ Male ☐ Female ☐ Other	☐ First ☐ Second If second, please indicate the date of the first dose: (YYYY/MM/DD)

Reason for immunization

Health Care Worker ☐ Yes ☐ No

If yes please indicate your employer on the right →

☐ Long term care worker ☐ Long-term care residents ☐ Group Home ☐ Shelter
☐ Indigenous - First Nations community member: ☐ On reserve ☐ Off reserve
☐ General Population

☐ Vitalité Health Network ☐ Horizon Health Network ☐ EM/ANB ☐ Private practice
☐ Other (specify)

Section 2 Health information for the person being immunized (If you need more space, use the other side of this form.)

***Immunizers: please review relevant vaccine information sheet(s) with the person being immunized.**

☐ No ☐ Yes Has this person ever had a COVID-19 infection?
If yes, please indicate when the symptoms started or date of positive test results and describe any treatments received (monoclonal antibodies or convalescent plasma) _____

☐ No ☐ Yes Is this person feeling ill today or has any symptoms of COVID-19?

☐ No ☐ Yes Does this person have any allergies, including allergies to any components of the vaccine or to medicine?
If yes, describe _____

☐ No ☐ Yes Does this person have any conditions or problems with their immune system, diagnosed with an auto-immune condition or taking medication or IV infusions which affects the immune system? (List all if more than one)
If yes, describe _____

☐ No ☐ Yes Is this person taking any medicine, like anticoagulants (blood thinner) or have a bleeding disorder?
If yes, describe _____

☐ No ☐ Yes Is this person pregnant? ☐ No ☐ Yes Is this person breastfeeding?

☐ No ☐ Yes Has this person ever had a side effect from a COVID-19 vaccine or any other vaccine?
If yes, describe _____

☐ No ☐ Yes Has this person received a vaccine of any kind in the last 14 days; or plan on receiving a vaccine other than COVID-19 in the next 4 weeks?

☐ No ☐ Yes Has this person ever felt faint or fainted after a past vaccination or medical procedure?

Section 3 Consent

For the two doses of the COVID-19 vaccine, your consent will confirm the following:

- I have read the information I was given on COVID-19 vaccine being offered to me today and consent to have administered the two required doses.
- I understand the benefits and possible reaction(s) for the COVID-19 vaccine and the risk of not being immunized.
- I have had an opportunity to discuss my questions and concerns as they relate to the COVID-19 vaccine.
- I understand that I may withdraw this consent at any time by informing the health care provider giving the COVID-19 vaccine.
- I confirm that I have the legal authority to consent to this immunization.

Printed name of person giving consent		Signature of person giving consent		Date (YYYY/MM/DD)

Relationship to person given consent: ☐ Parent (with legal authority to consent) ☐ Guardian/Legal representative

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COVID-19	Lot # Date of exp.	Site	Route	Dosage (ml)	Date (YYYY/MM/DD)	Time	Print name and signature of immunizer
Dose #1 - Please circle the vaccine being given: Moderna Pfizer-BioNTech AstraZeneca COVISHIELD		☐ Right arm ☐ Left arm	☐ IM	_____ ml			
Dose #2 - Please circle the vaccine being given: Moderna Pfizer-BioNTech AstraZeneca COVISHIELD		☐ Right arm ☐ Left arm	☐ IM	_____ ml			

Should you decide to provide all of the information requested on the form, it is important to know that its submission constitutes consent to the collection, use and disclosure of your personal information.

The collection use and disclosure of personal information is protected by the *Right to Information and Protection of Privacy Act* (RTIPPA), *Personal Health Information Privacy and Access Act* (PHIPAA) and all other applicable legislation, regulation or policy.

If you wish to know more about your privacy rights, please consult: https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/HealthActs/PrivacyNotice.pdf

New Nouveau Brunswick