COVID-19 VACCINE CHILDREN/ YOUTH Consent Form (Age 5-17)

Hauser's PHARMACY

Youth Name (First & Last):		Health Card (OHIP) Number:
Date of Birth: (YYYY/DD/MM)	Youth Gender Associated with Healthcard: (billing purposes) ☐Male ☐Female ☐X	Parent Email: Parent Phone:
Mailing Address:		
Emergency Contact: (Name, Phone Number, Relationship)		
Has the Youth previously received doses of a COVID-19 vaccine? If yes, please complete the information below First Dose :M___ /D____/Y____		Second Dose :M___ /D____/Y____ Product Type:

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' or the 'COVID-19 Vaccine Information Sheet: For Children (age 5-11)'. I have had the opportunity to ask questions regarding the vaccine and to have them answered to my satisfaction.

☐I consent (or am consenting on the patients behalf) to receiving all recommended doses in the vaccine series.

Acknowledgement of Collection, Use and Disclosure of Personal Health Information

The personal health information on this form is being collected in accordance with the COVID 19, Vaccination Reporting Act, 2021 for the purpose of providing care and creating an immunization record, 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 in accordance with the Personal Health Information Protection Act, 2004 and as 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.

Patient/ Agent Name (& Relationship)	Patient/ Agent Signature	Date Signed:

FOR CLINIC USE ONLY

Vaccine Lot: Phizer COVID-19 Vaccine	Anatomical Site: ☐Left Deltoid ☐Right Deltoid
Date of Immunization: (MM/DD/YYYY)	
Pharmacist:	OCP #