

# COVID-19 Vaccine Consent Form

## CONSENT FORM – Pfizer-BioNTech COVID-19 Vaccine

Version 1.1 – December 14, 2020

Last Name		First Name		Identification (e.g., health card number)	
Home Phone		Mobile Phone	Email Address		Primary Care Clinician (Family Physician or Nurse Practitioner)
Street Address			City		Province      Postal Code
Date of Birth <small>(month, day, year)</small>	Age	Is this your <b>first or second dose</b> of the vaccine? <input type="checkbox"/> First <input type="checkbox"/> Second			
____ / ____ / ____		If second, please indicate the date of the first dose: ____ / ____ / ____ <small>(month, day, year)</small>			

**Please answer all questions below:**

<p><b>Do you have symptoms of COVID-19, for example, 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?</b></p> <p>If you are over 70 years of age, have you experienced an unexplained or increased number of falls, acute functional decline, worsening of chronic conditions or delirium?</p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes</p>	If yes, please provide details
<p><b>Are you immunosuppressed due to disease or treatment, or do you have an autoimmune disorder?</b></p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes</p>	If yes, please provide details
<p><b>Have you previously had an allergic reaction to any vaccine or any component of the Pfizer-BioNTech vaccine?</b></p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes</p>	If yes, please provide details
<p><b>Are you or could you be pregnant?</b></p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes</p>	If yes, please provide details
<p><b>Are you breastfeeding?</b></p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes</p>	If yes, please provide details
<p><b>Do you have a bleeding disorder or are taking medications that could affect blood clotting (e.g., blood thinners)?</b></p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes</p>	If yes, please provide details

<b>Have you ever felt faint after a past vaccination or medical procedure?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please provide details
<b>Are you allergic to polyethylene glycol which is contained in the vaccine?</b> It can be found in some products such as cosmetics, skin care products, laxatives, cough syrups, bowel preparation products for colonoscopy, and some foods and drinks. Tell the health care provider if you are allergic to anything that may contain polyethylene glycol. <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Uncertain	If yes, please provide details
<b>Have you received another vaccine (not a COVID-19 vaccine) in the past 14 days?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please provide details

<b>I have read (or it has been read to me) and I understand the 'COVID-19 Vaccine Information Sheet – Pfizer / BioNTech COVID-19 Vaccine'. I have had the opportunity to ask questions and to have them answered to my satisfaction.</b> <input type="checkbox"/> I consent to receiving the vaccine	<b>The personal health information on this form is being collected for the purpose of providing care to you. It will be used and disclosed for this purpose, 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.</b> <input type="checkbox"/> I acknowledge that I have read and understand the above statement.	<b>The hospital, local public health units and the Ministry of Health may wish to communicate with you for purposes related to the COVID-19 vaccine (for example, communications to remind you of follow-up appointments, to provide you with proof of vaccination, and to tell you about research projects.)</b> I consent to receiving communications by: <input type="checkbox"/> email <input type="checkbox"/> phone/SMS
---	--	---

Signature	Print Name	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.

FOR CLINIC USE ONLY			
Agent	COVID-19	Product Name	COVID-19 Pfizer Vaccine Pfiz.
Dose	0.3 ml	Lot Number	
Anatomical Site	<input type="checkbox"/> Left deltoid <input type="checkbox"/> Right deltoid	Route	Intramuscular
Dose Number	1 of 2		
Date / Time Given	____ / ____ / ____ (month, day, year) ____ : ____ am pm		
Reason for Immunization	Healthcare worker: <input type="checkbox"/> LTC Home <input type="checkbox"/> Retirement Home <input type="checkbox"/> Other		
Reason Immunization Not Given	Healthcare provider: <input type="checkbox"/> Determines immunization is contraindicated <input type="checkbox"/> Recommends imms but no consent received		
Adverse Event After Immunization?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Location	_____		
Given By (Name, Designation)	_____, _____		
Authorized By	_____		
Your dose 2 of 2 is scheduled for	____ / ____ / ____ (month, day, year) ____ : ____ am pm		