Ministry of Health

Ontario

COVID-19 Vaccine Youth (Age 12-17) Consent Form

CONSENT FORM –COVID-19 Vaccine

Version 1.0 – May 21, 2021

Last Name	First Name	Identification number (e.g., health card, passport, birth certificate, driver's license)

Gender:

☐ Female

☐ Male

☐ Other: _____

☐ Prefer not to answer

Name of your Primary Care Clinician (Family Physician, Pediatrician or Nurse Practitioner)

If Indigenous, please indicate your Indigenous identity:

☐ First Nations

☐ Métis (includes members of the Métis organization or Settlement)

☐ Inuk/ Inuit

☐ Other Indigenous, specify: _____

☐ Prefer not to answer

☐ Unknown

Mobile Phone	Parent or other Phone

Street Address	City
	Province
	Postal Code

Date of Birth*	School you will be attending in the fall of 2021
_____ / _____ / _____ month day year *You must be 12 or older at the time of your first dose	_____ ☐ Prefer not to answer Home school Unknown Not attending school

Is this your **first or second dose** of the vaccine?

☐ First

☐Second

If second, please indicate the date of the first dose and name of vaccine administered:

--------/----------/-------- (month, day, year)

_____ Name of vaccine administered for a 1st dose

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 Youth (age 12-17)' and 'What youth need to know about their 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 all recommended doses in the vaccine series.

OR

☐ I am a consenting on the patient's behalf and I confirm that I am the patient's substitute decision maker (e.g., parent, legal guardian).

- I understand that I may withdraw this consent at any time.

Note: Please contact the vaccination clinic where you are supposed to receive the Covid-19 vaccine 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 If consent has been withdrawn by a substitute decision maker of an individual who resides in a congregate setting, then the congregate setting must contact the local public health unit.

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. 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.**

You may be contacted by a hospital, local public health unit, or the Ministry of Health for purposes related to the COVID-19 vaccine (for example, to remind you of follow up appointments and to provide you with a record of immunization). If you agree to receiving these follow up communications by email or text/SMS, please indicate this using the box below.

☐ **I consent to receiving follow-up communications:**

☐ **by email**

☐ **by text/SMS**

If you agreed to be contacted by email or text/SMS, please provide your email address or your text/SMS number:

_____

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 in research 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 do not wish to be contacted about research studies, please indicate this below.

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

Consenting to be contacted about research studies will not impact your eligibility to receive the Covid-19 vaccine.

I consent to be contacted about COVID-19 vaccine related research studies:

☐ **by email** ☐ **by phone**

☐ **by text/SMS** ☐ **by mail**

If selected by email, please provide your email address: _____

☐ **I do not consent to be contacted about COVID-19 related research studies**

Signature	Print Name	Date of Signature

If signing for someone other than yourself, indicate your relationship to the person you are signing for:

_____

☐ If signing for someone other than myself, I confirm that I am the substitute decision maker.

FOR CLINIC USE ONLY							
Agent	COVID-19	Product Name		Lot #		Dose Amount:	
Anatomical Site	☐ Left deltoid ☐ Right deltoid		Route	Intramuscular (IM)		Dose #:	
Date Given	_____ / _____ / _____ (mm/dd/yyyy)		Time Given	____ : ____ am pm	AEFI? (after receiving current dose)	☐ Yes ☐ No	
Given By (Name, Designation)			Location				
Authorized By							
Reason for Immunization	☐ Youth 12+ ☐ Age Priority Population – Age Eligible Population ☐ Other reason: _____						
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:	_____ / _____ / _____ (mm/dd/yyyy) ____ : ____ am pm