## **COVID-19 Vaccine Consent Form** . . . . . . . . . . .

Se	ctions A, B	, C, D and E co	mpleted by:						
	Client	Parent	□ Legal decision n	naker 🗌	Other		(on behalf of	f client)	
Α.	Client Info	rmation - pleas	e print						
Surname					Given Names				
Address of residence					ı	Postal Co	ode		
Pŀ	one Numbe	r		Email					
Se	x Male 🗆	/ Female 🗌	/ X 🗆		te of Birth (yyyy/mm	n/dd)	//		
Ma	anitoba Heal	lth Number (6 di	gits)	Personal Health	n Information Numb	er (9 digits)			
Na	ime of schoo	)l		City/T	own	Gra	ade		
		tory of Client							
	If yes, desc	cribe	er symptoms that cou				□Yes		
	Do you hav If yes, desc	ve any known or cribe	suspected allergies (	examples: food, med	lications, environme		□Yes	□No	
3.	Do you hav	ve a known or su	ispected allergy to pol	yethylene glycol (PE	EG), polysorbate 80	or tromethamine?	□Yes	□No	
	If yes, desc	cribe	us reaction or conditio					□No	
5	Do you hav If yes, plea	Do you have any medical conditions that require regular visits to a doctor? f yes, please discuss with immunizer						□No	
6.	Have you r	eceived a vaccir	ne in the last 14 days?	)			□Yes	□No	
7.			tion that affects blood				□Yes	□No	
8.	Are you pre	egnant, planning	to become pregnant	or breastfeeding?			□Yes	□No	
9.	Is your imm	nune system sup	pressed due to disea	se (e.g., leukemia) c	or treatment (e.g,. hi	gh-dose steroids)?	□Yes	□No	
10	. Do you hav	/e an autoimmur	ne condition (e.g., Rhe	eumatoid Arthritis, M	ultiple Sclerosis)?		□Yes	□No	
11	. Do you hav	e a history of ve	nous sinus thrombosis	in the brain or a hist	ory of heparin-induc	ed thrombocytopenia	(HIT)?  Yes	□No	
12	. Have you	received any do	ses of a COVID-19 va	ccine?	□Yes □No	If yes, how many?			
13	. Have you	had a confirmed	COVID-19 infection?		□Yes □No	If yes, when?			
14			oclonal antibody treatr n the last 90 days?	nent (e.g., Sotrovima	ab, Casirivimab, Imo	devimab)	□Yes	□No	
Pu CC ac de	blic health h DVID-19 sind cessibility in scribe yours African South Asiar	ce May 2020. Th different comm self. Keeping tha Black □Chine n □Southeast	bus Identity ing information about the following questions nunities. We recognize it in mind, which of the ese □Filipino □La Asian □White □C ican Indigenous, do y	will help assess vac that this list of racia following best desc tin American □No Other	ccine coverage and I or ethnic identifier ribes the racial or e rth American Indige	determine the need for s may not exactly may thnic community that nous – that is, First N	or increased vac tch how you wo you belong to? ations, Metis or IPrefer not to a	uld Inuit	
l h ab	ave read an ove named	d understood th person as per se	ult immunizer if no sig e fact sheet(s) regard ection A. My consent a sk questions about th <b>Complete</b>	ing the risks and ber applies to all doses o	nefits of the vaccine of the vaccine neces vere answered to m	ssary to complete the y satisfaction.			
		the above name	maker ed person receiving th	e COVID-19 vaccine	2.Consent by of a consent to re	client eceiving the COVID-1	9 vaccine.		
					Date (yyyy/mm/dd)				
	Phone numb	oer							
	Date (yyyy/mm/dd) Signature								
	Signature								
E.	Consent fo	or use and discl	osure of contact infe	ormation	s use and disclosure	e of the contact inform	nation provided	by me	

I understand and authorize the Department of Health and Seniors Car	re's use and disclosure of the contact information provid
on this form to a third party organization for the sole purpose of contacting me to schedule my appointment for the second dose	Date
of the vaccine.	Signature



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Notice: Information about the immunizations you or your dependent(s) receive may be recorded in the provincial immunization registry. This registry allows your health care providers to find out what immunizations you or your dependent(s) have had or need to have. Information collected in the provincial immunization registry may be used to produce immunization records, or notify you or your doctor if a particular immunization has been missed. Manitoba Health and Seniors Care may use the information to monitor how well different vaccines work in preventing disease. The Personal Health Information Act protects your information. You can have your personal health information hidden from view from health care providers. For more information, please contact your local public health office to speak with a public health nurse <u>www.manitoba.ca/health/publichealth/offices.html</u>.

THE FOLLOWING SECTION TO BE COMPLETED BY THE IMMUNIZATION PROVIDER											
Clinic Location											
$\square$ Check this box if verbal consent has been obtained from client because they are unable to sign section D											
Reason for Immunization – please check the first reason that applies (Check ONLY the first box that applies)         1. □ Personal care home resident         2. □ Health care worker (includes all settings)         3. □ Community with disproportionate disease impact         4. □ Other congregate living (includes residents, non-health care staff, visitors, volunteers)         5. □ Routine (age)				<ul> <li>The following five interventions must be performed and documented with a check mark by the immunizer:</li> <li>1. Fact sheet(s) provided</li> <li>2. Section B completed and reviewed</li> <li>3. Expected benefits and material risks of vaccine provided</li> <li>4. Information provided about reporting vaccine side effects (reportable side effects pursuant to section 57(2) of the Public Health Act)</li> <li>5. Concerns and questions addressed</li> </ul>							
Clients who answer yes to questions 9, 10 and/or are receiving dose 3 (as per question 12) of section B: health care provider or immunizer must review the expected benefits and material risks of vaccination as per the Clinical Practice Guidelines. Immunizer or Health Care Provider Name (please print):											
Immunizer o	or Health Care Pro	ovider Signature:						Date	<u>.</u>		
Vaccine	Date Y/M/D	Lot #	Manufac	cturer	Route	Dose	Site	Immunizer's Signature	Data Entry		