

# Consent for COVID-19 vaccine doses

## Section 1 Personal Information

13430 (2021/09/14)

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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Is this your first, second or other dose of the vaccine? <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> Other What is the date of your most recent dose? (YYYY/MM/DD)		
Reason for immunization Health Care Worker <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please indicate your employer on the right		<input type="checkbox"/> Long term care worker <input type="checkbox"/> Long-term care residents <input type="checkbox"/> Group Home <input type="checkbox"/> Shelter <input type="checkbox"/> Indigenous - First Nations community member: <input type="checkbox"/> On reserve <input type="checkbox"/> Off reserve <input type="checkbox"/> General Population <input type="checkbox"/> Vitalité Health Network <input type="checkbox"/> Horizon Health Network <input type="checkbox"/> EM/ANB <input type="checkbox"/> Private practice <input type="checkbox"/> 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 Has this person ever been diagnosed with a condition known as Capillary Leaking Syndrome ?
- No  Yes Is this person pregnant?  No  Yes Is this person breastfeeding?
- No  Yes Has this person ever had a side effect from other non-covid vaccines or to a previous dose of a COVID-19 vaccine including myocarditis and / or pericarditis (following either Pfizer or Moderna)  
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?
- No  Yes Has this person filled out an attestation form to receive a third dose?

## Section 3 Consent

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

OFFICE USE ONLY	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		<input type="checkbox"/> Right arm <input type="checkbox"/> Left arm	<input type="checkbox"/> IM	_____ ml			
	Dose #2 - Please circle the vaccine being given: Moderna Pfizer-BioNTech		<input type="checkbox"/> Right arm <input type="checkbox"/> Left arm	<input type="checkbox"/> IM	_____ ml			
	Dose #3 - Please circle the vaccine being given: Moderna Pfizer-BioNTech		<input type="checkbox"/> Right arm <input type="checkbox"/> Left arm	<input type="checkbox"/> 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>