

# COVID-19 Vaccine Consent Form



Sections A, B, C and D completed by:

Client     Parent     Legal decision maker     Other \_\_\_\_\_ (on behalf of client)

## A. Client Information - please print

Surname \_\_\_\_\_ Given Names \_\_\_\_\_  
 Address of residence \_\_\_\_\_ City/Town \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Email \_\_\_\_\_  
 Sex Male  / Female  / Intersex  / Unknown  Date of Birth (yyyy/mm/dd) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Manitoba Health Number (6 digits) \_\_\_\_\_ Personal Health Information Number (9 digits) \_\_\_\_\_

## B. Health History of Client

1. Do you have a fever or other symptoms that could be due to COVID-19?  Yes  No  
If yes, describe \_\_\_\_\_
2. Do you have any known or suspected allergies (examples: food, medications, environmental)?  Yes  No  
If yes, describe \_\_\_\_\_
3. Do you have a known or suspected allergy to polyethylene glycol (PEG), polysorbate 80 or tromethamine?  Yes  No
4. Have you ever had a serious reaction or condition following any vaccine?  Yes  No  
If yes, describe \_\_\_\_\_
5. Do you have any medical conditions that require regular visits to a doctor?  Yes  No  
If yes, please discuss with immunizer \_\_\_\_\_
6. Have you received a vaccine in the last 14 days?  Yes  No
7. Are you taking any medication that affects blood clotting?  Yes  No  
If yes, please list \_\_\_\_\_
8. Are you pregnant, planning to become pregnant or breastfeeding?  Yes  No
9. Is your immune system suppressed due to disease (e.g., leukemia) or treatment (e.g., high-dose steroids)?  Yes  No
10. Do you have an autoimmune condition (e.g., Rheumatoid Arthritis, Multiple Sclerosis)?  Yes  No

## C. Informed Consent – Consult immunizer if no signature can be obtained

I have read and understood the fact sheet(s) regarding the risks and benefits of the vaccine that I am consenting be administered to the above named person as per section A. My consent applies to all doses of the vaccine necessary to complete the series up to one year. I have had the opportunity to ask questions about the vaccine(s) which were answered to my satisfaction.

**Complete ONLY ONE of the following two options:**

### 1. Consent by legal decision maker

I consent to the above named person receiving the COVID-19 vaccine.

Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Phone number \_\_\_\_\_  
 Date \_\_\_\_\_  
 Signature \_\_\_\_\_

### 2. Consent by client

I consent to receiving the COVID-19 vaccine.

Date \_\_\_\_\_  
 Signature \_\_\_\_\_

## D. Consent for Use and Disclosure of Contact Information

I understand that appointments for administration of the second dose of the COVID-19 vaccine are not being scheduled at this time. I understand and authorize the Department of Health and Seniors Care's use and disclosure of the contact information provided by me on this form to a third party organization for the sole purpose of contacting me to schedule my appointment for the second dose of the vaccine, if/when scheduling of these appointments resumes.

Date \_\_\_\_\_

Signature \_\_\_\_\_

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 [www.manitoba.ca/health/publichealth/offices.html](http://www.manitoba.ca/health/publichealth/offices.html).

## THE FOLLOWING SECTION TO BE COMPLETED BY THE IMMUNIZATION PROVIDER

Clinic Location \_\_\_\_\_  
 Check this box if verbal consent has been obtained from client because they are unable to sign section C

**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)

The following five interventions must be performed and documented with a check mark by the immunizer:

1.  Fact sheet(s) provided
2.  Section B completed and reviewed
3.  Expected benefits and material risks of vaccine provided
4.  Information provided about reporting vaccine side effects (reportable side effects pursuant to section 57(2) of the Public Health Act)
5.  Concerns and questions addressed

**Clients who answer yes to questions 8, 9 or 10 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 or Health Care Provider Signature: \_\_\_\_\_ Date \_\_\_\_\_

Vaccine	Date Y/M/D	Lot #	Manufacturer	Route	Dose	Site	Immunizer's Signature	Data Entry