Ministry of Health

Ontario

COVID-19 Vaccine Screening and Consent Form

SCREENING AND CONSENT FORM –COVID-19 Vaccine

Version 1.0 – December 30, 2020

Last Name	First Name		Identification (e.g., health card number)	
Sex: ☐Female ☐Male ☐Non-Binary ☐Prefer not to answer			Primary Care Clinician (Family Physician or Nurse Practitioner)	
Home Phone	Mobile Phone	Email Address		
Street Address		City	Province	Postal Code
Date of Birth (month, day, year) _____ /_____/ _____	Age	**Which dose** of the vaccine ☐First ☐Second ☐Third ☐Fourth ☐Fifth Please indicate the date of the **Last** dose: _____ /_____/_____(month, day, year)		

Please answer all questions below:

Do you have symptoms of COVID-19 or feel ill today*?, ☐ No ☐Yes	If yes, please provide details
Have you previously had an allergic reaction to any vaccine (including your first COVID-19 vaccination if applicable) or any component of the Pfizer-BioNTech or Moderna vaccine? ☐ No ☐Yes	If yes, please provide details
Are you allergic to polyethylene glycol (PEG) which is contained in the vaccine?** *Talk with your health care provider if you are known to be allergic to polyethylene glycol** or have had an allergic reaction from an unknown cause. See below for more details*** ☐ No ☐Yes ☐Uncertain	If yes, please provide details
Have you received another vaccine (not a COVID-19 vaccine) in the past 14 days? *You will be asked to wait for two weeks from the other vaccine to receive your COVID-19 vaccine* ☐ No ☐Yes	If yes, please provide details
Are you or could you be pregnant? ☐No ☐Yes	If yes, please provide details
Are you breastfeeding? ☐No ☐Yes	If yes, please provide details
Do you have any problems with your immune system or are you taking any medications that can affect your immune system (e.g., high dose steroids, chemotherapy)? *Ask the health care provider if you are not sure about your medical conditions* ☐ No ☐Yes	If yes, please provide details
Do you have an autoimmune disease? *Ask the health care provider if you are not sure about your medical conditions*	

☐ No ☐Yes	
Do you have a bleeding disorder or are taking medications that could affect blood clotting *(e.g., blood thinners)? Ask the health care provider if you are not sure about your medical conditions* ☐ No ☐Yes	If yes, please provide details
Have you ever felt faint or fainted after a past vaccination or medical procedure? ☐ No ☐Yes	If yes, please provide details

* Symptoms of COVID-19 can include 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 or, for those over 70 years of age, an unexplained or increased number of falls, acute functional decline, worsening of chronic conditions or delirium	** Polyethylene glycol (PEG) can rarely cause allergic reactions and is found in products such as medications, bowel preparation products for colonoscopy, laxatives, cough syrups, cosmetics, skin creams, medical products used on the skin and during operations, toothpaste, contact lenses and contact lens solution. PEG also can be found in foods or drinks, but is not known to cause allergic reactions from foods or drinks

I have read (or it has been read to me) and I understand the 'COVID-19 Vaccine Information Sheet'. I have had the opportunity to ask questions and to have them answered to my satisfaction. ☐ I consent to receiving the vaccine	**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*.** ☐ I acknowledge that I have read and understand the above statement.	**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.)** I consent to receiving communications by: ☐ email ☐ 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		Lot #		Dose	
Anatomical Site	☐ Left deltoid ☐Right deltoid			Route	Intramuscular	Dose #	
Date Given	_____ /_____/_____(m/d/yyyy)		Time Given	____ :____am pm		AEFI?	☐ Yes ☐No
Given By (Name, Designation)		Location			Authorized By		
Reason for Immunization	☐ Healthcare worker ☐Healthcare worker: LTC Home ☐Healthcare worker: Retirement Home ☐ LTC Home: Resident ☐Retirement Home: Resident ☐Advanced age: community dwelling ☐ Other employees in acute care, LTC, RHs ☐Indigenous community ☐Adult of chronic health care						
Reason Imms Not Given	Healthcare provider: ☐Determines immunization is contraindicated ☐Recommends immunization but no consent received ☐Determines that immunization will be temporarily deferred						
Your dose 2 of 2 is scheduled for:	_____ /_____/_____(month, day, year) _____ :_____ am pm						