WHOLEHEALTH PHARMACY PARTNERS

COVID-19 Vaccine Screening & Consent Form

Last Name	First Name	Identification (e.g., health card #)	
Gender ☐ Female ☐ Male ☐ Non-Binary ☐ Prefer not to answer ☐ Other: _____		Primary Care Clinician (Family Physician or Nurse Practitioner):	
Home Phone	Mobile Phone	Email Address	
Street Address	City	Province	Postal Code
Patient Date of Birth ___/____/____ (month, day, year)	**Has the patient previously received one or more doses of a COVID-19 vaccine?** If yes, please complete the information below for all doses of vaccine received. Number of doses received to date: _____		
Age	Date of most recent dose: _____		

Please answer all the questions below:

Has the patient tested positive for COVID-19 in the last 6 months? ☐ No ☐ Yes	If yes, please provide date:
Has the patient experienced major venous and/or arterial thrombosis with thrombocytopenia following vaccination with any vaccine? ☐ No ☐ Yes	If yes, please provide details:
Has the patient experienced a previous cerebral venous sinus thrombosis (CVST) with thrombocytopenia or a heparin induced thrombocytopenia (HIT)? ☐ No ☐ Yes	If yes, please provide details:
Has the patient experienced a previous episode of capillary leak syndrome? ☐ No ☐ Yes	If yes, please provide details:
Has the patient been diagnosed with myocarditis or pericarditis following a dose of an mRNA COVID-19 vaccine? ☐ No ☐ Yes	If yes, please provide details:

Has the patient been sick in the past few days? Does the patient have symptoms of COVID-19 or have a fever today*? ☐ No ☐ Yes	If yes, please provide details:
Has the patient currently receiving monoclonal antibodies or convalescent plasma for the treatment or prevention of COVID-19? ☐ No ☐ Yes	If yes, please provide details:
Has the patient had a serious allergic reaction or a reaction within 4 hours to the COVID-19 vaccine before? ☐ No ☐ Yes	If yes, please provide details:
Does the patient have allergies to polyethylene glycol [PEG], tromethamine (found in Moderna, pediatric Pfizer, grey-cap Pfizer) or polysorbate (found in viral vector vaccines, Covifenz, Nuvaxovid)?** ☐ No ☐ Yes	If yes, please provide details:
Has the patient had a serious allergic reaction to a vaccine or medication given by injection (e.g., IV, IM), needing medical care? ☐ No ☐ Yes	If yes, please provide details:
Does the patient have a weakened immune system or is the patient taking any medications that can weaken their immune system (e.g., high dose steroids, chemotherapy)? ☐ No ☐ Yes **If yes, is the patient receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies or other targeted agents?** ☐ No ☐ Yes	If yes, please provide details:
Does the patient have a bleeding disorder or is the patient taking blood thinning medications? ☐ No ☐ Yes	If yes, please provide details:
Has the patient ever felt faint or fainted after receiving a vaccine or medical procedure? ☐ No ☐ Yes	If yes, please provide details:
For <u>children</u> 6 months to 5 years of age: Has the child received ANY vaccine in the past 14 days? ☐ No ☐ Yes	If yes, please provide details:
Has the patient experienced Multi-System Inflammatory Syndrome (MIS-C or MISC-A) within the past 90 days? ☐ 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. Polysorbate may also cause allergic reactions because of crossreactivity with PEG.

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', for children (6 months+): 'COVID-19 Vaccine Information Sheet.' I have had the opportunity to ask questions regarding the vaccine and to have them answered to my satisfaction. I understand I may withdraw consent at any time.

☐ **I consent to receiving all recommended doses in the series**

OR

☐ **I am a consenting on the patient's behalf to receive all recommended doses in the vaccine series and I confirm that I am the patient's substitute decision maker (e.g., parent, legal guardian).**

Signature of patient/agent	Print Name of patient/agent	Date of Signature

☐ If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker. Relationship to patient:_____

FOR PHARMACY USE ONLY:

Agent	COVID-19	☐ Pfizer Peds (5-11) Orange Cap DIN 02522454 ☐ Pfizer (12+) Purple Cap DIN: 02509210 ☐ Pfizer (12+) Grey Cap DIN: 02527863 ☐ Moderna Red Cap (DIN: 02510014) ☐ Moderna Peds Blue Cap, Purple Label (6 months) DIN 02527685 ☐ Moderna **Bivalent** Blue Cap, Green Label DIN 02530252 ☐ Nuvaxovid DIN 02525364 ☐ Other:_____	Lot #	
			Dose	

Anatomical Site	☐ Left deltoid ☐ Right deltoid	Route	Intramuscular (IM)	Dose #:	
Date Given	____/____/____ (month, day, year)	Time Given	____ :____ am pm	AEFI? (after current dose)	☐ Yes ☐ No
Given By (Name, Designation)		Pharmacy address		Immunizer signature	
Reason for Immunization					
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				
Next dose scheduled for:	____/____/____ (month, day, year) ____ :____ am pm ☐ Not applicable				