Huron Perth Public Health

COVID-19 Vaccination
Client Information Sheet

Vaccine Recipient Information:		
Last Name:	First Name:	Health Card Number:
Date of Birth (mm/dd/yyyy):	Phone Number:	Email Address:
Street Address:	City:	Postal Code:
Name of Primary Care Provider (family doctor):	If applicable, Name of School attending 2022/23 (Name of School & City/Town):	

If Indigenous, please indicate indigenous identity:

☐ First Nations ☐ Metis ☐ Inuk/Inuit ☐ Other Indigenous _____ ☐ Prefer not to answer ☐ Unknown

Acknowledgement of Collection, Use and Disclosure of Personal Health Information (PHI)

The PHI on this form is being collected for the purpose of providing care to you and creating an immunization record for you. It may be disclosed as part of your provincial electronic health record, to healthcare providers who are providing care to you. The information will be stored in a health record system under the custody and control of the Ministry of Health.

☐ I acknowledge that I have read and understand the above statement.

Consent to Receiving Follow Up Communications

You may be contacted by a hospital, local public health unit, or the Ministry of Health for purposes related to the COVID-19 vaccine (for example, to remind you of follow up appointments and to provide you with proof of vaccination). If you consent to receiving these follow up communications by email or text/SMS, please indicate this using the boxes below.

☐ **I consent to receiving follow-up communications:** ☐ by email ☐ by text/SMS

Consent to Being Contacted About Research Studies

Many research studies will be conducted in respect of COVID-19 vaccines. If you consent to be contacted, your personal health information will be used to determine which studies may be relevant to you, and your name and contact information will be disclosed to researchers. Consenting to be contacted about research studies does not mean you have consented to participate in the research itself.

☐ **I consent to being contacted about research studies:**

☐ by email ☐ by text/SMS ☐ by phone ☐ by mail ☐ I do not consent to be contacted

Consent to Receive Vaccine:

☐ **Proxy consent:** If signing for someone other than myself, I confirm that I am the substitute decision maker (e.g., parent, legal guardian).

Relationship to person signing for: _____

☐ **Client consent:** I consent to receiving the vaccine, including all recommended doses in the series. I understand that I may withdraw this consent at any time.

Signature	Print Name	Date of Signature

FOR CLINIC USE ONLY		
Days since last vaccine:	Client age:	Vaccine Sticker:
Agent: **COVID**	Anatomical Site: ☐ Left Deltoid ☐ Right Deltoid	
Date Given: (dd/mm/yyyy)	Time Given: ☐ am ☐ pm	Given By: (Name, Designation) *[please print]*

You will go over these questions when you talk with your vaccinator:

- ☐ Have you been diagnosed with myocarditis or pericarditis following an mRNA COVID-19 vaccine?
- ☐ Have you ever had myocarditis or pericarditis before?
- ☐ Do you have today, or have you recently had new/unexplained shortness of breath or chest pain?
- ☐ Have you been sick in the past few days? Do you have symptoms of COVID-19 or have a fever today?
- ☐ Have you had a serious allergic reaction or a reaction within 4 hours to the COVID-19 vaccine before?
- ☐ Do you have allergies to polyethylene glycol, tromethamine or polysorbate?
- ☐ Have you had a serious allergic reaction to a vaccine or medication given by injection (e.g., IV, IM), needing medical care?
- ☐ Do you have a weakened immune system or are you taking any medications that can weaken your immune system (e.g., high dose steroids, chemotherapy)?
  - If yes, are you receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies or other targeted agents?
  - If on one of the therapies listed; have you spoken with your treating health care provider about getting the vaccine?
- ☐ Do you have a bleeding disorder or are you taking blood thinning medications?
- ☐ Have you ever felt faint or fainted after receiving a vaccine or medical procedure?

For children only between the ages of 5 to 11

- ☐ Do you have a previous history of multisystem inflammatory syndrome in children (MIS-C), unrelated to any previous COVID-19 vaccination?
  - If yes, vaccination should be postponed until clinical recovery has been achieved or until it has been ≥ 90 days since diagnosis, whichever is longer.
- ☐ Have you received another vaccine (not a COVID-19 vaccine) in the past 14 days?

COMMENTS:
