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 2021/22 (Name of School & City/Town):	

If Indigenous, please indicate indigenous identity

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

Vaccine dose receiving today:

☐ First dose ☐ Second dose ☐ Third dose

Previous doses received	FIRST DOSE	SECOND DOSE
DATE:		
BRAND:		

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 receiving follow-up communications:

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

☐ If signing for someone other than myself, I confirm that I am the substitute decision maker.

Relationship to person signing for: _____

I consent to receiving the vaccine, including all recommended doses in the series. OR; I consent on patient's behalf to receive the vaccine, including all recommended doses in the series and I confirm I am the patient's substitute decision maker (e.g. parent, legal guardian).

Signature	Print Name	Date of Signature

FOR CLINIC USE ONLY | to be used only during COVAX database outage		
Agent: COVID	Product Name and Lot Number	Anatomical Site: ☐ Left Deltoid ☐ Right Deltoid
Date Given: (dd/mm/yyyy)	Time Given: am/pm	Given By: (Name, Designation) *[please print]*