

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 in fall 2021: (Name of School & City/Town)

Is this your first second or third dose of the vaccine?

Date of: _____ first dose _____ second dose (mm/dd/yyyy)

Brand: _____ first dose _____ second dose

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

I consent to receiving the vaccine, including all recommended doses in the series.

Signature	Print Name	Date of Signature
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FOR CLINIC USE ONLY

(to be used only during COVAX database outage)

Agent: COVID	Product Name and Lot Number:	Anatomical Site: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid
Date Given: _____ _____ _____ dd/mm/yyyy		Time Given: _____ am / pm
Given By: (Name, Designation) <i>please print</i>		