Huron Perth Public Health

COVID-19 Vaccine Consent Form

Last Name:	First Name:	Health Card Number:	
Date of Birth: (m/d/yyyy)	**Phone Number:**	**Email Address:**	
Street Address:		**City:**	**Postal Code:**
Name of Primary Care Provider:			

Is this your first or second dose of the vaccine? ☐ First ☐ Second

If this is your second dose, Date of First Dose: ____________________ (m/d/yyyy) Brand: _________________________

The personal health information on this form is being collected for the purpose of providing care to you and creating an immunization record for you, and because it is necessary for the administration of Ontario's COVID-19 vaccination program. This information will be used and disclosed for these purposes, as well as other purposes authorized by law. For example,

- It will be disclosed to the Chief Medical Officer of Health and Ontario public health units where disclosure is necessary for a purpose of the *Health Protection and Promotion Act,* and
- It may be disclosed, as part of your provincial electronic health record, to health care 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.

Where a Clinic Site is administered by a hospital, the hospital will collect, use and disclose your information as an agent of the Ministry of Health.

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

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

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☐ **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

☐ Vaccination screening questions complete

Agent: COVID-19	Product Name:		Lot Number:
Anatomical Site: ☐ Left deltoid ☐ Right Deltoid	Route: Intramuscular		AEFI ☐ Yes ☐ No
Date Given: ________/_________/__________ (m/d/yyyy)	Time Given: ______:______ am / pm		
Given by: (Name, Designation) *Please print*	Clinic location:		