COVID-19 VACCINE CONSENT FORM

1. PATIENT INFORMATION

Name _____ Address _____

Date of Birth _____ Phone Number _____

Personal Health Number _____

Emergency Contact Name_____ Emergency Contact Phone _____

2. SCREENING AND HEALTH INFORMATION

As of today:	Yes	No
Are you experiencing cold, flu, or COVID-19-like symptoms, **even mild ones**? Symptoms include: fever, chills, cough, shortness of breath, sore throat/painful swallowing, stuffy/runny nose, loss of sense of smell, headache, muscle aches, fatigue, loss of appetite, conjunctivitis, dizziness, confusion, nausea, vomiting, abdominal pain, skin rashes, discolouration of fingers or toes - or **any other suspected COVID-19 symptoms**?		
Within the last 14 days, did you **provide care** or had **close contact** with a person with confirmed COVID-19 or someone who is under investigation for COVID-19?		
Do you have any allergies? Please list: (foods, medications, vaccine components)		
If yes, do you have a severe allergy to: 1)Polyethylene glycol (PEG) - contained in the Moderna and PfizerBioNTech COVID-19 vaccines. PEG can be found in some cosmetics, skin care products, laxatives, cough syrups, and bowel preparation products for colonoscopy. 2)Polysorbate 80 – contained in the AstraZeneca and Verity Pharmaceuticals vaccines. It is also found in medical preparations (e.g., vitamin oils, tablets and anticancer agents) and cosmetics 3) Anaphylaxis from an unknown cause (if yes, consider referral to an allergist before immunization)		
Have you received any vaccinations in the last 2 weeks?		
Have you ever had a COVID-19 vaccine before? If yes, please list type of vaccine and date received:		
Have you ever fainted or had a serious reaction to any previous injection or vaccine(s) including Guillain- Barre Syndrome?		
Do you have any chronic health conditions or immunodeficiencies? Please list:		
Are you currently on any medications or immunosuppressants? Please list:		
Are you pregnant or breastfeeding?		
Have you had previous lab-confirmed COVID-19 disease within the last 3 months?		
Have you been hospitalized because of COVID-19 infection? If yes, were you treated with convalescent plasma or monoclonal antibody within the last 3 months?		

3. PATIENT CONSENT

- I have had the opportunity to read and understand the benefits, side effects and risks of receiving and risks of not receiving the COVID-19 vaccine.
- I have had the opportunity to ask questions and I have received satisfactory answers.
- I agree to stay in the pharmacy for at least 15 minutes after receiving the vaccine or as directed by the pharmacists.
- I authorize my pharmacist to notify my physician/nurse practitioner and/or public health of the vaccine received, any adverse events experienced and/or to contact me with any follow-up if needed. I consent to receive the COVID-19 vaccine today

Print Name _____ Signature _____

Date _____ Relationship (if applicable) _____

4. VACCINE INFORMATION PHARMACIST USE ONLY:

Pharmacy Name: Pharmasave Parksville Phone Number: (250) 951-0227

Vaccine			**Notes/Observations** (15-30min wait)
AstraZeneca Pfizer Johnson+Johnson Moderna Other:	**Dose**	0.5mL 0.3mL	
	Time of Administration		
Pharmacist Signature:	**Administration Site**	IM Deltoid R L	