COVID-19 Vaccine Consent Form

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female ☐ Other
Year Month Day

Health Card Number (if available): _____

Address: _____

Personal phone number: (_____) _____

Please answer the following questions:

Have you received a dose of any COVID-19 vaccine?	☐ Yes	☐ No
Have you had a reaction to any previous vaccines?	☐ Yes	☐ No
Do you have any medical conditions that the nurse should be aware of?	☐ Yes	☐ No
Do you have any serious allergies (other than environmental)?	☐ Yes	☐ No

PLEASE SIGN THIS AREA IF YOU WISH TO BE VACCINATED

I have read or had explained to me the information about COVID-19 vaccine. I have had a chance to ask questions which have been answered to my satisfaction.

☐ If signing for someone other than myself, I confirm that I have the legal authority to provide consent for the individual that is to receive the COVID-19 vaccine.

☐ If Applicable: I consent to having my retirement residence receive a copy of this completed form.

_____ OR _____
Consent – Self signature Consent – Substitute Decision Maker

_____ _____
Name of person signing (please print) Date

FOR OFFICE USE ONLY

Health Status Reviewed: □ Yes □ No

The person named above received the COVID-19 vaccine as follows:

Dosage: ☐ 0.25 ml ☐ 0.3 ml ☐ 0.5 ml Vaccine Name: _____

Lot # _____ Expiry Date: _____

Date: _____/_____/_____ Time: _____ R / L Deltoid Intramuscularly
Year Month Day

R / L Thigh Intramuscularly

Comments:

Nurse's Signature and Designation:

We collect, use, and disclose your personal and personal health information under the authority of the Health Protection and Promotion Act, R.S.O. 1990, c.H.7, s.5. This information is collected for the purpose of assessing, keeping records, and reporting. Information collected is maintained electronically within a provincial immunization information system provided by the Ontario Ministry of Health. Information will be collected, used, and disclosed in accordance with the Personal Health Information Protection Act (PHIPA), 2004, S.O. 2004, c.3. Should you have any questions about this collection of information, please contact the Health Unit's Designated Privacy Officer, 200 Rose Glen Road, Port Hope, Ontario, L1A 3V6 or call 1-844-575-4567.