Huron Perth Public Health

Panorama ID #: _____

Use this form to request consent for receiving a COVID-19 and/or influenza immunization.

COVID-19 and/or Influenza Immunization Consent Form

COVID-19 and influenza vaccine *recipient* information

1

First name: _____ Last name: _____

Date of Birth: _____ Age: _____ Sex: M ☐ F ☐ Other ☐

Address *(not P.O. Box)*: _____

Health Card #: _____ Daytime Phone # _____

For children age 6 months to 8 years old:
Is this the child's first influenza immunization? ☐ No ☐ Yes

For children age 6 months to 4 years old:
Is this the child's first COVID-19 immunization? ☐ No ☐ Yes

Personal health information

This information is collected under the authority of the ***Health Protection and Promotion Act*** and the ***Personal Health Information Protection Act*** for the purpose of administering the COVID-19/ Influenza program and documenting in Panorama provincial immunization database.

2

Have you had a COVID-19 or influenza immunization in the last 3 months? ☐ No ☐ Yes

Have you ever had a reaction to an immunization? ☐ No ☐ Yes

Do you have any serious allergies? *(Please discuss with the nurse)* ☐ No ☐ Yes

Do you have any serious health and/or immune system problems, or are taking medication for any serious health concerns? ☐ No ☐ Yes

Do you have a history of seizures, fainting or asthma? ☐ No ☐ Yes

Have you ever had Guillain-Barre Syndrome (GBS) or Oculorespiratory Syndrome (ORS) requiring hospitalization or associated with severe lower respiratory symptoms following an influenza immunization? ☐ No ☐ Yes

Have you ever had myocarditis, pericarditis, multi-system inflammatory syndrome (MIS-C-A) or Bell's Palsy following a COVID-19 immunization? ☐ No ☐ Yes

If you answered yes to any of the above questions, please explain.

_____

_____

Health history reviewed ☐ *(nurse's initials)*

Consent *(required)*

I have read or had explained to me the information about the COVID-19/Influenza vaccine. I have had the chance to ask questions and understand the answers provided to me.

3

☐ YES, I consent to receiving the **influenza** vaccine. ☐ NO, I do not consent

☐ YES, I consent to receiving the **COVID-19** vaccine. ☐ NO, I do not consent

Signature _____ Print name _____ Date of signature _____

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

Relationship to person receiving the vaccine: _____

To be completed by nurse

Notes:

_____

_____

_____

_____

4

Influenza Vaccine	Dose:			Data entered ☐
Date	Time	Lot # | Vaccine Name	Site	Initials
			L or R Deltoid Anterolateral thigh	

COVID-19 Vaccine	Dose:			Data entered ☐
Date	Time	Lot # | Vaccine Name	Site	Initials
			L or R Deltoid Anterolateral thigh	