ALBERTA COVID-19 PHARMACY IMMUNIZATION PROGRAM CONSENT & SCREENING FORM

Personal Information for the person being immunized		
Name (Last, First,Middle)	Date of Birth (dd-mm-yy)	Weight:
Personal Health Number (PHN)	Emergency Contact Name & Phone #	

Health Information for the person being immunized	
Are you sick today? (i.e. fever greater than 39.5ºC, breathing problems, or active infection)	☐ Yes ☐ No
Do you have any allergies, including allergies to latex, any vaccine, medicine, or food? If yes, please describe.	☐ Yes ☐ No
Have you had a serious reaction to, or fainted after receiving any vaccine (including COVID) in the past?	☐ Yes ☐ No
Do you have any chronic illness or take any medications?	☐ Yes ☐ No
Are you pregnant or breastfeeding?	☐ Yes ☐ No
Have you had lymph nodes removed from your arms or chest or had a mastectomy?	☐ Yes ☐ No
Have you received a vaccination in the last 14 days?	☐ Yes ☐ No
Have you had COVID-19 vaccine before and/or had a reaction to COVID-19 vaccine?	☐ Yes ☐ No
Do you take blood thinning medications, or do you have a bleeding disorder?	☐ Yes ☐ No

Consent for Immunization

I confirm that I have read the COVID-19 vaccine information. I know about and understand the risks, benefits, and common side effects of this vaccine. Any questions I may have had about this person getting this vaccine have been answered by calling the local public health office or Health Link at 811.

I understand the information I have been given.

I understand this consent is for all doses of the vaccine.

I will contact the local public health office or the healthcare provider giving the COVID-19 vaccine if the person being immunized:

- has any changes to their health before getting any dose of the COVID-19 vaccine
- gets another vaccine in the 14 days before they get any dose of the COVID-19 vaccine
- has a severe or unusual side effect after the first dose of the COVID-19 vaccine (other than the expected side effects listed on the COVID-19 vaccine information sheet provided)

I consent to this person getting the COVID-19 immunization.

I understand that I may withdraw this consent at any time by calling the healthcare provider giving the COVID-19 vaccine.

I confirm that I have the legal authority to consent to this immunization.

Printed name of person giving consent	Daytime Telephone Number	Alternate Telephone Number

Relationship to person being immunized (select one)

Person being immunized | Parent (with legal authority to consent) | Guardian/Legal representative
Co-decision-maker | Specific decision-maker | Agent

Signature of person giving consent	Date (dd-mm-yy)
Name of healthcare provider obtaining the consent	Signature of healthcare provider obtaining the consent

---------- BELOW LINE FOR PHARMACY USE ONLY- ADD NOTES ON REVERSE AS NEEDED ----------

Check Box to Confirm Patient Identity Verified ☐ **Check box to Confirm Vaccine/Drug to be administered Verified** ☐

Vaccine & DIN	Lot#	Exp Date	Manufacturer	Dosage	Site of Injection	Sequence	Time
				mL	**IM L / R Deltoid**		

Written info and verbal counseling provided to patient ☐

Additional Assessment Notes (if applicable) : _____

Monitoring Post-Injection: ☐ Well Tolerated Reaction? : ☐ No ☐ Yes_____

Signature of Immunizer : _____ **License/Permit #**_____ **Date:** _____