Health PEI

COVID Immunization Clinic Registration Form

Date of Clinic: _____ Location of Clinic: _____

Client Name: _____ Health Card #: _____

DOB: _____ Age: _____Sex: _____

Civic Address:_____ Postal Code: _____

Telephone:_____ Email:_____

Target Population: *select all groups to which you belong*

- ☐ Health Care Worker with direct or indirect patient care
- ☐ Congregate living setting for seniors – resident
- ☐ Partner in Care for senior in congregate living setting
- ☐ Other congregate living settings – resident or staff
- ☐ Indigenous communities on reserve
- ☐ Indigenous communities off reserve
- ☐ Non-health Essential Worker 1
  (e.g. police, firefighter, armed forces, deployed personnel)
- ☐ Non-health Essential Worker 2
  (e.g. transportation worker, grocery store worker, agricultural worker)
- ☐ Person with underlying medical condition(s) or their family
- ☐ School student

Health Conditions: *can be one to many*

- ☐ Diabetes
- ☐ Chronic Respiratory Disease
  (i.e. COPD, asthma)
- ☐ Cardiovascular Disease
  i.e. hypertension, ischemic heart disease, heart failure, stroke
- ☐ Neurological Disease
  i.e. dementia, MS, epilepsy, Parkinson's disease
- ☐ Cancer

Ethnicity: *can be one to many*

- ☐ Asian
- ☐ Black
- ☐ East/Southeast Asian
- ☐ Indigenous
  - If Indigenous, to which do you identify:
    - ☐ First Nations
    - ☐ Métis
    - ☐ Inuk/Inuit
    - ☐ Other, specify: _____
    - ☐ Unknown
    - ☐ Prefer not to say
  - If First Nations, which community:
    - ☐ Abegweit First Nation/ Epekwitk
    - ☐ Lennox Island First Nation/ L'nui Mnikuk
    - ☐ Other, specify: _____
    - ☐ Prefer not to say
- ☐ Latino
- ☐ Middle Eastern
- ☐ South American
- ☐ South Asian
- ☐ White
- ☐ Other, specify: _____
- ☐ Unknown
- ☐ Prefer not to say

Part 1: To be completed by Client/Parent/Guardian:

I have read or have had the information sheets about the COVID 19 immunization read to me and understand the information about the immunization that will be received by the above named individual. The nature and anticipated effect of this immunization including the risks and benefits have been explained to me and I am satisfied with these explanations and I understand them. I have had the opportunity to ask questions and have them answered. I consent to receiving this immunization and any follow up immunizations that may be required.

Print name (client/parent/guardian) _____ Date: _____

Signature: _____ Relationship to the client: _____

See Reverse for Additional Details

Part 2: To be completed by Health care Provider: ***HCP Screening***	
Are you sick? Do you have any symptoms of COVID 19?	Yes ☐ No ☐
Do you have any allergies? Any previous severe or anaphylactic reaction to a vaccine?	Yes ☐ No ☐
Are you immunosuppressed due to disease or treatment?	Yes ☐ No ☐
Are you pregnant or breastfeeding?	Yes ☐ No ☐
Have you received a vaccine in the past 14 days?	Yes ☐ No ☐
Have you read the fact sheet and understand the information?	Yes ☐ No ☐

DOSE 1 VACCINE ADMINISTRATION DATE:_____

Moderna 0.5mL☐ Site: IM Deltoid Right ☐ Left ☐ Lot # _____
Expiry Date: _____ HCP Administering:_____

DOSE 2 VACCINE ADMINISTRATION DATE:_____

Moderna 0.5mL☐ Site: IM Deltoid Right ☐ Left ☐ Lot # _____
Expiry Date: _____ HCP Administering:_____

Personal health information on this form is collected for the purposes of the provision of health care. Your information will be collected, used, and disclosed only as permitted by the *Health Information Act, RSPEI 1988, c H-1.41*, and other applicable legislation. For more information on privacy and your personal health information, visit www.healthpei.ca/yourprivacy or contact (902) 368-6157.

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