SK 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:
Address (Street, City, Postal Code)		
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? If Yes, please provide name of vaccine and date of last dose:	□ Yes □ No
Do you take blood thinning medications, or do you have a bleeding disorder?	□ Yes □ No
Have you had a previous COVID-19 infection? If Yes, were you treated with convalescent plasma or monoclonal antibodies?	□ Yes □ No □ Yes □ No □ Unsure

Consent for Immunization

I have read or had explained to me the vaccine information sheet regarding the risks, benefits and potential side effects associated with the vaccine. I have had the opportunity to have my questions answered by the pharmacist and understand the information I have been given. I understand the need for observation by the vaccine provider for at least 15 minutes after my vaccination.

I understand health information may be shared with another healthcare provider as necessary for care.

I consent to the vaccine provider administering the vaccine for myself or my child /dependent. 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/Guardian □ Authorized decision-maker		
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:** _____

Revised 23-11-2021