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? 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

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:** _____