medSask
YOUR MEDICATION INFORMATION SERVICE

COVID-19 Vaccine Screening and Consent Form

Vaccine Recipient Information	
Name: (Last, First)	**Date of Birth: (MM-DD-YY)**
Address:	**Health Services Number:**
Phone Number:	**Sex: Male Female Other**
Emergency Contact Information **Name:**	**Phone Number:**

Do you work in a healthcare facility or live in a personal care home? Yes No

If yes, what type: SHA non-SHA SHA LTC non-SHA LTC PCH PCH Resident

(SHA=Saskatchewan Health Authority; LTC= long-term care; PCH=personal care home)

Screening

The following questions will help determine if a vaccine is right for you. A "yes" to any question does not necessarily mean you should not be vaccinated, but your pharmacist may have some additional questions.

Question		
1. Have you received any previous COVID-19 vaccine? (Assessor: if "yes", document on page 2)	**Yes**	**No**
1a. Any side effects after previous dose(s)?:	**Yes**	**No**
2. Have you had a **previous COVID-19 infection**?	**Yes**	**No**
2a. If yes to Question 2, were you treated with **convalescent plasma** or **monoclonal antibodies**?	**Yes** **Don't know**	**No**
3. Do you have any **severe allergies** such as anaphylaxis (e.g. difficulties breathing, itchy/swelling of mouth or throat, hives, feeling faint, persistent vomiting/diarrhea) to any medication(s), vaccine(s) or food(s) or from an unknown cause? If yes, please describe:	**Yes**	**No**
4. Are you **pregnant**, could you be pregnant or are you planning on becoming pregnant before receiving both doses of the vaccine?	**Yes**	**No**
5. Are you **nursing/breastfeeding**?	**Yes**	**No**
6. Do you have an **autoimmune disorder**? (examples: Crohn's disease, lupus, multiple sclerosis, psoriasis, rheumatoid arthritis, type 1 diabetes)	**Yes**	**No**
7. Are you **immunosuppressed or immunocompromised** due to treatment/disease? **Medications** that affect immune system such as prednisone, other steroids, anticancer medications, transplant medications, medications used to treat inflammatory conditions (examples: Crohn's disease, psoriasis, rheumatoid arthritis). If unsure, ask your pharmacist. **Cancer Transplant HIV**	**Yes**	**No**
8. Do you have a **bleeding disorder** that makes you bleed easier or are you **taking blood thinners** (examples: Aspirin, warfarin, Eliquis®, Lixiana®, Pradaxa®, Xarelto®)	**Yes**	**No**
9. Do you have a history of • **heparin-induced thrombocytopenia (HIT)** or • **thrombosis associated with lupus anticoagulant** (thrombotic antiphospholipid syndrome) or • **cerebral venous sinus thrombosis (CVST) with thrombocytopenia** or • **venous or arterial thrombosis with thrombocytopenia following AstraZeneca, COVISHIELD vaccines** or • **capillary leak syndrome?**	**Yes**	**No**
10. Have you received **any other vaccines** in the past 14 days?	**Yes**	**No**
Assessing Pharmacist (Name):		

Vaccine Providers: see the accompanying Guide for interpretation of responses

Declaration of Consent:

- 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.

______________________________________ ____________________

Signature of: ¨ **Vaccine Recipient** ¨ **Parent /Guardian** ¨ **Proxy** **Date**

____

Name (if not signed by vaccine recipient)

***Pharmacies: for 3rd and 4th doses, recipients also need to sign this form.**

For Pharmacy Use Only			
Vaccine recipients who work in healthcare facilities or are residents of a PCH must be entered into the Vaccine Risk Factor Portal before entering the prescription and billing to DPEBB. Category (if applicable): SHA SHA LTC non-SHA non-SHA LTC PCH PCH Resident (HCW= healthcare worker; LTC= long-term care; PCH=personal care home; SHA=Saskatchewan Health Authority)			
This section applies to those who have received previous dose(s) :			
	COVID-19 Vaccine Name	**Date Received**	**Minimum Interval Met** (See Guide Q1)
1st Dose			**Yes** **No** (between 1st and 2nd)
2nd Dose (if applicable)			**Yes** **No** (between 2nd and 3rd)
3rd Dose (if applicable)			**Yes** **No** (between 3rd and 4th)

Vaccine Details

Vaccine Name: **Age Appropriate**	**Manufacturer:**	**DIN:**	**Lot #:**	**Expiry Date:**

Vaccine Preparation

Vaccine Drawn by (Name):	**Date & Time Vaccine Drawn:**

Vaccine Administration

Dosage:	**Site:**	**Route:**	**Dose #:**	**Vaccine Administered by (Name):**	**Date & Time of Injection:**

Adverse reaction: **No** **Yes – describe reaction below**

Completed Adverse Event Following Immunization (AEFI) form

(See https://formulary.drugplan.ehealthsask.ca/COVIDImmunizationProgram, Section 8 for form and reporting instructions.)

Vaccine Name	**Manufacturer**	**DIN**	**Dose**
AstraZeneca COVID-19 Vaccine (**8** doses per vial)	AST	02511444	0.5 mL
AstraZeneca COVID-19 Vaccine (**10** doses per vial)	AST	02510847	0.5 mL
COVISHIELD	Verity	02512947	0.5 mL
Janssen COVID-19 Vaccine	JAN	02513153	0.5 mL
Moderna COVID-19 Vaccine	Moderna	02510014	0.5 mL
Pfizer-BioNTech COVID-19 Vaccine (PFI)	PFI	02509210	0.3 mL

No part of this work may be reproduced, distributed, or transmitted in any form or by any means unless authorized by medSask.
For copyright permission requests, please contact druginfo@usask.ca.
Last updated 20 Aug 2021