COVID-19 VACCINE CONSENT FORM

Bonafide Compounding Pharmacy, 1598 Leger Way, Milton ON L9E 0B9
Phone: (905) 636-7880 Fax: (905) 875-9881

PATIENT INFORMATION

First Name	*Last Name*	*Gender*	*DOB*
Weight	*Address*		*Phone Number*
Emergency Contact #1	*Relationship to Patient*	*Contacts Phone Number*	
Emergency Contact #2	*Relationship to Patient*	*Contacts Phone Number*	

SCREENING QUESTIONNAIRE **Circle Your Answer**

Have you had a COVID vaccine? If so, which one did you receive and when did you receive it? Detail:	YES	NO	UNSURE
Have you experienced major venous and/or arterial thrombosis with thrombocytopenia following vaccination with any vaccine? (This question is for patients receiving a viral vector based COVID vaccine.)	YES	NO	UNSURE
Have you experienced a previous cerebral venous sinus thrombosis (CVST) with thrombocytopenia or a heparin induced thrombocytopenia (HIT)? (This question is for patients receiving a viral vector based COVID vaccine.)	YES	NO	UNSURE
Are you experiencing any cold, flu or COVID-19-like symptoms, even mild ones? Sore throat, cough, fever, diarrhea	YES	NO	UNSURE
Have you travelled to any countries outside Canada (including the United States) within the last 14 days?	YES	NO	UNSURE
Did you provide care or have close contact with a person with confirmed COVID-19?	YES	NO	UNSURE
Have you received a flu vaccine or any vaccine in the past 14 days?	YES	NO	UNSURE

Do you have a new or changing neurological disorder?	YES	NO	UNSURE
Have you had a serious reaction to a vaccine in the past?	YES	NO	UNSURE
Have you ever had a serious reaction to polyethylene glycol	YES	NO	UNSURE
Have you ever had Guillain-Barre Syndrome within 6 weeks after receiving a vaccine? (A Yes answer is not a contraindication for mRNA based vaccines).	YES	NO	UNSURE
Are you or do you think you might be pregnant?	YES	NO	UNSURE
Are you currently taking any medication?	YES	NO	UNSURE
Do you take a blood thinner or have a bleeding disorder?	YES	NO	UNSURE
Do you have an autoimmune disorder or weakened immunity due to illness/treatment?	YES	NO	UNSURE
Are you allergic to latex gloves?	YES	NO	UNSURE
Do you have a history of chronic illness?	YES	NO	UNSURE
Do you have a history of fainting?	YES	NO	UNSURE

CONSENT GIVEN BY PATIENT/GUARDIAN/AGENT

I, the undersigned patient/guardian/agent, have read or had explained to me information about the COVID shot as outlined on the Fact Sheet. I have had a chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the COVID shot. I agree to wait/have my child wait/have the client wait in the pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the COVID shot. I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called "anaphylaxis" can be life-threatening and is a medical emergency. If I/my child/my client experience such a reaction following vaccination, I am aware that it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 9-1-1 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. In the event of anaphylaxis, a copy of this form containing information on emergency treatments received will be provided to you, your guardian, your agent or EMS paramedics.

□ I confirm that I want to receive the COVID vaccine

OR

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

Patient/Guardian/Agent Name	*Patient/Guardian/Agent Signature*	*Relationship*	*Date Signed*

PHARMACIST DECLARATION I confirm the above named patient/guardian/agent is capable of providing consent for COVID vaccine and that the COVID vaccine should be given to the patient.

Pharmacist	*Pharmacist Signature*	*Date Signed*

Immunization Record

PHARMACY USE ONLY

First Name	*Last Name*	*Gender*	*Weight*	*DOB*
Address	*Health Card #*		*Phone #*	

COVID-19 VACCINE

Product	**DIN**	**DOSE**
□AstraZeneca COVID-19 Vaccine 50000000000 VP / 0.5 (Pack Size 4 ML)	**02511444**	
□AstraZeneca COVID-19 Vaccine 50000000000 VP / 0.5 (Pack Size 5 ML)	**02510847**	
□Moderna COVID-19 Vaccine 100mcg/0.5mL (Pack Size 5 ML)	**02510014**	
□Pfizer-Biontech COVID-19 Vaccine 30mcg/0.3mL (Pack Size 1.8 ML)	**02509210**	
□ Comirnaty 10mcg/0.2mL (Pack Size 2 ML)	**02522454**	
□		

Route of Administration	*Site of Administration*	*Lot Number*	*Expiry Date*

Administered by Name and OCP #	*Administered By <Pharmacist>*	*Date/Time of Immunization*

EPINEPHRINE EMERGENCY TREATMENT

Product	**DIN**	**PIN**	**DOSE**
□ Allerject 0.15mg/0.15ml (Pack Size 1 PEN) - ODB emergency use	**02382059**	**09857439**	**1 Pen**
□ Allerject 0.3mg/0.3ml (Pack Size 1 PEN) - ODB emergency use	**02382067**	**09857440**	**1 Pen**
□ Emerade 0.3mg/0.3mL (Pack Size 0.3 ML) - ODB emergency use	**02458446**	**09858129**	**1 Pen**
□ Emerade 0.5mg/0.5mL (Pack Size 0.5 ML) - ODB emergency use	**02458454**	**09858130**	**1 Pen**
□ Epipen 1mg/mL (Pack Size 1 PEN) - ODB emergency use	**00509558**	**09857423**	**1 Pen**
□ Epipen Jr 0.15mg/0.3mL (Pack Size 1 PEN) - ODB emergency use	**00578657**	**09857424**	**1 Pen**

Route of Administration	*Site of Administration*	*Lot Number*	*Expiry Date*
Administered by Name and OCP #	*Administered By <Pharmacist>*	*Date/Time of Immunization*	

Comments