WHOLEHEALTH PHARMACY PARTNERS

wholehealth pharmacy partners

COVID-19 Vaccine Screening & Consent Form

<table>
<tr><td>Last Name</td><td>First Name</td><td colspan="2">Identification (e.g., health card #)</td></tr>
<tr><td colspan="2">Gender
☐ Female ☐ Male ☐ Non-Binary
☐ Prefer not to answer ☐ Other: ____________________</td><td colspan="2">Primary Care Clinician (Family Physician or Nurse Practitioner):</td></tr>
<tr><td>Home Phone</td><td>Mobile Phone</td><td colspan="2">Email Address</td></tr>
<tr><td>Street Address</td><td>City</td><td>Province</td><td>Postal Code</td></tr>
<tr><td>Patient Date of Birth
___/____/____
(month, day, year)</td><td colspan="3" rowspan="2">Has the patient previously received one or more doses of a COVID-19 vaccine? If yes, please complete the information below for all doses of vaccine received.
First dose date: ___/____/____ (month, day, year)
First dose vaccine: ___________
Second dose date: ___/____/____ (month, day, year)
Second dose vaccine: ___________</td></tr>
<tr><td>Age</td></tr>
</table>

<table>
<tr><td colspan="2"><u>Please answer all the questions below:</u></td></tr>
<tr><td>Has the patient experienced major venous and/or arterial thrombosis with thrombocytopenia following vaccination with any vaccine?
☐ No ☐ Yes</td><td>If yes, please provide details:</td></tr>
<tr><td>Has the patient experienced a previous cerebral venous sinus thrombosis (CVST) with thrombocytopenia or a heparin induced thrombocytopenia (HIT)?
☐ No ☐ Yes</td><td>If yes, please provide details:</td></tr>
<tr><td>Has the patient experienced a previous episode of capillary leak syndrome?
☐ No ☐ Yes</td><td>If yes, please provide details:</td></tr>
<tr><td>Has the patient been diagnosed with myocarditis or pericarditis following a dose of an mRNA COVID-19 vaccine?
☐ No ☐ Yes</td><td>If yes, please provide details:</td></tr>
</table>

Has the patient been sick in the past few days? Does the patient have symptoms of COVID-19 or have a fever today*? ☐ No ☐ Yes	If yes, please provide details:
Has the patient currently receiving monoclonal antibodies or convalescent plasma for the treatment or prevention of COVID-19? ☐ No ☐ Yes	If yes, please provide details:
Has the patient had a serious allergic reaction or a reaction within 4 hours to the COVID-19 vaccine before? ☐ No ☐ Yes	If yes, please provide details:
Does the patient have allergies to polyethylene glycol [PEG], tromethamine (Moderna & pediatric Pfizer only) or polysorbate?** ☐ No ☐ Yes	If yes, please provide details:
Has the patient had a serious allergic reaction to a vaccine or medication given by injection (e.g., IV, IM), needing medical care? ☐ No ☐ Yes	If yes, please provide details:
Does the patient have a weakened immune system or is the patient taking any medications that can weaken their immune system (e.g., high dose steroids, chemotherapy)? ☐ No ☐ Yes **If yes, is the patient receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies or other targeted agents?** ☐ No ☐ Yes	If yes, please provide details:
Does the patient have a bleeding disorder or is the patient taking blood thinning medications? ☐ No ☐ Yes	If yes, please provide details:
Has the patient ever felt faint or fainted after receiving a vaccine or medical procedure? ☐ No ☐ Yes	If yes, please provide details:
For children 5-11 years of age: Has the child received ANY vaccine in the past 14 days? ☐ No ☐ Yes	If yes, please provide details:
For children 5-11 years of age: Has the child experienced Multi-System Inflammatory Syndrome (MIS- C) within the past 90 days? ☐ No ☐ Yes	If yes, please provide details:

* **Symptoms of COVID-19** can include fever, new onset of cough or worsening of chronic cough, shortness of breath, difficulty breathing, sore throat, difficulty swallowing, decrease or loss of smell or taste, chills, headaches, unexplained tiredness / malaise / muscle aches, nausea / vomiting, diarrhea or abdominal pain, pink eye, or runny nose or nasal congestion without other known cause or, for those over 70 years of age: an unexplained or increased number of falls, acute functional decline, worsening of chronic conditions or delirium.

****Polyethylene glycol (PEG)** can rarely cause allergic reactions and is found in products such as medications, bowel preparation products for colonoscopy, laxatives, cough syrups, cosmetics, skin creams, medical products used on the skin and during operations, toothpaste, contact lenses and contact lens solution. PEG also can be found in foods or drinks, but is not known to cause allergic reactions from foods or drinks. Polysorbate may also cause allergic reactions because of crossreactivity with PEG.

Consent to Receive the Vaccine:

I have read (or it has been read to me) and I understand the Immunization Prepackage, including the following documents: 'COVID-19 Vaccine Information Sheet' and 'What you need to know about your Covid-19 vaccine appointment'. For children (5-11): 'COVID-19 Vaccine Information Sheet.' I have had the opportunity to ask questions regarding the vaccine and to have them answered to my satisfaction. I understand I may withdraw consent at any time.

☐ **I consent to receiving all recommended doses in the series**

OR

☐ **I am a consenting on the patient's behalf to receive all recommended doses in the vaccine series and I confirm that I am the patient's substitute decision maker (e.g., parent, legal guardian).**

Signature of patient/agent	Print Name of patient/agent	Date of Signature

☐ If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker. Relationship to patient:_________________________

FOR PHARMACY USE ONLY:

Agent	COVID-19	Product Name	☐ **Pediatric (5-11)** Pfizer-BioNTech (DIN 02522454) ☐ **Adult/Adolescent (12+)** Pfizer-BioNTech (DIN: 02509210) ☐ Moderna (DIN: 02510014) ☐ Other:___________	Lot #	
				Dose	
Anatomical Site	☐ Left deltoid ☐ Right deltoid	Route	Intramuscular (IM)	Dose #:	
Date Given	____/____/____ (month, day, year)	Time Given	_____ :______ am pm	AEFI? (after current dose)	☐ Yes ☐ No
Given By (Name, Designation)		Pharmacy address		Immunizer signature	
Reason for Immunization					
Reason Immunization Not Given	☐ Immunization is contraindicated ☐ Practitioner recommends immunization but no PATIENT consent ☐ Practitioner decision to temporarily defer immunization ☐ Medically Ineligible ☐ Patient withdrew consent for series				
Next dose scheduled for:	____/____/____ (month, day, year) _______ :_____am pm ☐ Not applicable				