COVID-19 Vaccine Consent Form

Manitoba

Sections A, B, C, D and E completed by:

☐ Client ☐ Parent ☐ Legal decision maker ☐ Other _____ (on behalf of client)

A. Client Information - please print

Surname _____ Given Names _____

Address of residence _____ City/Town _____ Postal Code _____

Phone Number _____ Email _____

Sex Male ☐ / Female ☐ / X ☐ Date of Birth (yyyy/mm/dd) _____ / _____ / _____

Manitoba Health Number (6 digits) _____ Personal Health Information Number (9 digits) _____

Name of school _____ City/Town _____ Grade _____

B. Health History of Client

1. Do you have a fever or other symptoms that could be due to COVID-19? ☐Yes ☐No
   If yes, describe _____
2. Do you have any known or suspected allergies (examples: food, medications, environmental)? ☐Yes ☐No
   If yes, describe _____
3. Do you have a known or suspected allergy to polyethylene glycol (PEG), polysorbate 80 or tromethamine? ☐Yes ☐No
4. Have you ever had a serious reaction or condition following any vaccine? ☐Yes ☐No
   If yes, describe _____
5 Do you have any medical conditions that require regular visits to a doctor? ☐Yes ☐No
   If yes, please discuss with immunizer _____
6. Have you received a vaccine in the last 14 days? ☐Yes ☐No
7. Are you taking any medication that affects blood clotting? ☐Yes ☐No
   If yes, please list _____
8. Are you pregnant, planning to become pregnant or breastfeeding? ☐Yes ☐No
9. Is your immune system suppressed due to disease (e.g., leukemia) or treatment (e.g,. high-dose steroids)? ☐Yes ☐No
10. Do you have an autoimmune condition (e.g., Rheumatoid Arthritis, Multiple Sclerosis)? ☐Yes ☐No
11. Do you have a history of venous sinus thrombosis in the brain or a history of heparin-induced thrombocytopenia (HIT)? ☐Yes ☐No
12. Have you received any doses of a COVID-19 vaccine? ☐Yes ☐No If yes, how many?_____
13. Have you had a confirmed COVID-19 infection? ☐Yes ☐No If yes, when?_____
14. Have you received a monoclonal antibody treatment (e.g., Sotrovimab, Casirivimab, Imdevimab) for a COVID-19 infection in the last 90 days? ☐Yes ☐No

C. Racial, Ethnic or Indigenous Identity

Public health has been collecting information about the racial, ethnic, Indigenous identity of individuals who are diagnosed with COVID-19 since May 2020. The following questions will help assess vaccine coverage and determine the need for increased vaccine accessibility in different communities. We recognize that this list of racial or ethnic identifiers may not exactly match how you would describe yourself. Keeping that in mind, which of the following best describes the racial or ethnic community that you belong to?

☐African ☐Black ☐Chinese ☐Filipino ☐Latin American ☐North American Indigenous – that is, First Nations, Metis or Inuit
☐South Asian ☐Southeast Asian ☐White ☐Other _____ ☐Prefer not to answer

If you identified as North American Indigenous, do you identify as: ☐First Nations ☐Metis ☐Inuit ☐Not Applicable

D. Informed consent – Consult immunizer if no signature can be obtained

I have read and understood the fact sheet(s) regarding the risks and benefits of the vaccine that I am consenting be administered to the above named person as per section A. My consent applies to all doses of the vaccine necessary to complete the series up to one year. I have had the opportunity to ask questions about the vaccine(s) which were answered to my satisfaction.

Complete ONLY ONE of the following two options:

1. Consent by legal decision maker

I consent to the above named person receiving the COVID-19 vaccine.

Name _____

Relationship _____

Phone number _____

Date (yyyy/mm/dd) _____

Signature _____

2. Consent by client

I consent to receiving the COVID-19 vaccine.

Date (yyyy/mm/dd) _____

Signature _____

E. Consent for use and disclosure of contact information

I understand and authorize the Department of Health and Seniors Care's use and disclosure of the contact information provided by me on this form to a third party organization for the sole purpose of contacting me to schedule my appointment for the second dose of the vaccine.

Date _____

Signature _____

Notice: Information about the immunizations you or your dependent(s) receive may be recorded in the provincial immunization registry. This registry allows your health care providers to find out what immunizations you or your dependent(s) have had or need to have. Information collected in the provincial immunization registry may be used to produce immunization records, or notify you or your doctor if a particular immunization has been missed. Manitoba Health and Seniors Care may use the information to monitor how well different vaccines work in preventing disease. The Personal Health Information Act protects your information. You can have your personal health information hidden from view from health care providers. For more information, please contact your local public health office to speak with a public health nurse www.manitoba.ca/health/publichealth/offices.html.

THE FOLLOWING SECTION TO BE COMPLETED BY THE IMMUNIZATION PROVIDER

Clinic Location _____

☐ Check this box if verbal consent has been obtained from client because they are unable to sign section D

Reason for Immunization – please check the first reason that applies (Check ONLY the first box that applies)

1. ☐ Personal care home resident
2. ☐ Health care worker (includes all settings)
3. ☐ Community with disproportionate disease impact
4. ☐ Other congregate living (includes residents, non-health care staff, visitors, volunteers)
5. ☐ Routine (age)

The following five interventions must be performed and documented with a check mark by the immunizer:

1. ☐ Fact sheet(s) provided
2. ☐ Section B completed and reviewed
3. ☐ Expected benefits and material risks of vaccine provided
4. ☐ Information provided about reporting vaccine side effects (reportable side effects pursuant to section 57(2) of the Public Health Act)
5. ☐ Concerns and questions addressed

Clients who answer yes to questions 9, 10 and/or are receiving dose 3 (as per question 12) of section B: health care provider or immunizer must review the expected benefits and material risks of vaccination as per the Clinical Practice Guidelines.

Immunizer or Health Care Provider Name (please print): _____

Immunizer or Health Care Provider Signature: _____ Date _____

Vaccine	Date Y/M/D	Lot #	Manufacturer	Route	Dose	Site	Immunizer's Signature	Data Entry