COVID-19 Immunization Consent Form

Manitoba

Region _____ Clinic Location _____ Date _____

SECTIONS A, B, C AND D COMPLETED BY:

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

A. Client Information - please print

Surname _____ Given Names _____

Address _____ City/Town _____ Postal Code _____

Home Phone _____ Date of Birth (yyyy/mm/dd) _____/ _____/ _____

Sex Male☐ / Female☐ / Intersex☐ / Unknown☐

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

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 allergies? ☐Yes ☐No
   If yes, describe _____
3. Have you ever had a serious reaction or condition following any vaccine? ☐Yes ☐No
   If yes, describe _____
4. Do you have any conditions that require regular visits to a doctor? ☐Yes ☐No
   If yes, please discuss with immunizer _____
5. Is your immune system suppressed due to a disease or treatment, or do you have an autoimmune disorder? ☐Yes ☐No
   If yes, please discuss with immunizer _____
6. Are you pregnant or breastfeeding? ☐Yes ☐No
   If yes, please discuss with immunization provider. _____
7. Have you received any vaccine in the last 14 days? ☐Yes ☐No
   _____
8. Are you taking any medication that affects blood clotting? ☐Yes ☐No
   If yes, please list _____
   _____

C. Reason for Immunization – Please check the first reason that applies (Check ONLY the first box that applies)

1.☐Health care worker (includes all settings) **2.**☐Personal care home resident

3.☐Other congregate living (includes residents, non-health care staff, visitors, volunteers)

Health care workers only • indicate your primary work setting: ☐Long-term care / PCH Community Acute ☐Community ☐Acute

• print your facility / office name _____

D. Informed Consent – Consult immunization provider if no signature can be obtained

I have read and understood the fact sheet(s) regarding the vaccine(s) that I am consenting be administered to the above named person as indicated below. My consent applies to all doses of the vaccine necessary to complete the series. 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 COVID-19 vaccine.

Name _____

Relationship _____

Phone number _____

Date _____

Signature _____

2. Consent by client

I consent to receiving COVID-19 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, Seniors and Active Living 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 IMMUNIZATION PROVIDER

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

1. ☐ Fact sheet(s) provided
2. ☐ Health history 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

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

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