

# COVID-19 Vaccine Consent Form



## 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?  0 Doses  Dose 1  Dose 2
13. 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 \_\_\_\_\_

