

COVID-19 Vaccine Consent Form



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 of residence _____ City/Town _____ Postal Code _____
Phone Number _____ Email _____
Sex Male / Female / Intersex / Unknown Date of Birth (yyyy/mm/dd) _____ / _____ / _____
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 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

C. 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 _____
Signature _____

2. Consent by client

I consent to receiving the COVID-19 vaccine.

Date _____
Signature _____

D. Consent for Use and Disclosure of Contact Information

I understand that appointments for administration of the second dose of the COVID-19 vaccine are not being scheduled at this time. 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, if/when scheduling of these appointments resumes.

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.

