ALBERTA COVID-19 PHARMACY IMMUNIZATION PROGRAM CONSENT AND SCREENING FORM

Personal Information for the person being immunized	
Name (Last,First,Middle)	Date of Birth (dd-mm-yy)
Personal Health Number (PHN)	Gender (optional)

Health Information for the person being immunized	
Does this person have any allergies, including allergies to any vaccine, medicine, or food? ☐ No ☐ Yes If yes, describe all (list)	
Does this person have any chronic illness? ☐ No ☐ Yes If yes, describe all (list)	
Is this person taking any medicine? ☐ No ☐ Yes If yes, describe all (list)	
Is this person pregnant? ☐ No ☐ Yes	Is this person breastfeeding? ☐ No ☐ Yes
Has this person had COVID-19 vaccine before? ☐ No ☐ Yes If yes, when (dd-mm-yy)	
Has this person ever had a side effect from COVID-19 immunization? ☐ No ☐ Yes If yes, describe all (list)	
Will this person get another vaccine in the 14 days before they get the COVID-19 vaccine? ☐ No ☐ Yes If yes, describe all (list)	

Consent for Immunization

I confirm that I have read the COVID-19 vaccine information. I know about and understand the risks, benefits, and common side effects of this vaccine. Any questions I may have had about this person getting this vaccine have been answered by calling the local public health office or Health Link at 811.

I understand the information I have been given.

I understand this consent is for all doses of the vaccine.

I will contact the local public health office or the healthcare provider giving the COVID-19 vaccine if the person being immunized:

- has any changes to their health before getting any dose of the COVID-19 vaccine
- gets another vaccine in the 14 days before they get any dose of the COVID-19 vaccine
- has a severe or unusual side effect after the first dose of the COVID-19 vaccine (other than the expected side effects listed on the COVID-19 vaccine information sheet provided)

I consent to this person getting the COVID-19 immunization.

I understand that I may withdraw this consent at any time by calling the healthcare provider giving the COVID-19 vaccine.

I confirm that I have the legal authority to consent to this immunization.

Printed name of person giving consent	Daytime Telephone Number	Alternate Telephone Number

Relationship to person being immunized (select one)

☐ Person being immunized	☐ Parent (with legal authority to consent)	☐ Guardian/Legal representative
☐ Co-decision-maker	☐ Specific decision-maker	☐ Agent

Signature of person giving consent	Date (dd-mm-yy)
Name of healthcare provider obtaining the consent	Signature of healthcare provider obtaining the consent