

# COVID-19 Vaccine Screening Form

## SCREENING–COVID-19 Vaccine

Version 3.0 – August 17, 2021

Last Name		First Name		Identification number (e.g., health card, passport, birth certificate, driver's license)	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____				Name of your Primary Care Clinician (Family Physician or Nurse Practitioner)	
Home Phone	Mobile Phone	Email Address			
Street Address			City	Province	Postal Code
Date of Birth (month, day, year)  ____ / ____ / ____	Age	Have you previously received one or more doses of a COVID-19 vaccine? If yes, please complete the information below for all doses of vaccine received.  First Dose date: -----/-----/----- (month, day, year) First dose name: _____  Second Dose date: -----/-----/----- (month, day, year) Second dose name: _____			

**Please answer all questions below:**

If the client is receiving the AstraZeneca/COVISHIELD or Janssen COVID-19 Vaccine, the following three questions apply:	
<b>Have you experienced major venous and/or arterial thrombosis with thrombocytopenia following vaccination with any vaccine?</b>  <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please provide details
<b>Have you experienced a previous cerebral venous sinus thrombosis (CVST) with thrombocytopenia or a heparin-induced thrombocytopenia (HIT)?</b>  <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please provide details

<p><b>Have you experienced a previous episode of capillary leak syndrome?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p><b>Have you been diagnosed with myocarditis or pericarditis following the first dose of an mRNA COVID-19 vaccine?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p><b>Have you been sick in the past few days? Do you have symptoms of COVID-19 or have a fever today?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p><b>Have you had a serious allergic reaction within 4 hours to the COVID-19 vaccine before?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p><b>Do you have allergies to polyethylene glycol, tromethamine (Moderna only) or polysorbate?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p><b>Have you had a serious allergic reaction to a vaccine or medication given by injection (e.g., IV, IM), needing medical care?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p><b>Have you received another vaccine (not a COVID-19 vaccine) in the past 14 days?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p><b>Do you have a weakened immune system or are you taking any medications that can weaken your immune system (e.g., high dose steroids, chemotherapy)?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p><b>If yes, are you receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies or other targeted agents?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p><b>Do you have a bleeding disorder or are taking blood thinners?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p><b>Have you ever felt faint or fainted after receiving a vaccine or medical procedure?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>

## Consent to Receive the Vaccine

I have read (or it has been read to me) and I understand the Immunization Prepackage, including the following documents: 'COVID-19 Vaccine Information Sheet' and 'What you need to know about your Covid-19 vaccine appointment'.

- I have had the opportunity to ask questions regarding the vaccine I am receiving and to have them answered to my satisfaction.

**I consent to receiving the vaccine, including all recommended doses in the series.**

- I understand that I may withdraw this consent at any time.
- I understand that if I am withdrawing consent as a substitute decision maker of an individual, then I must contact the congregate setting that the individual resides in.

**Note: Please contact the vaccination clinic where you are supposed to receive the Covid-19 vaccine if you change your mind and no longer consent to receiving the vaccine. This will allow someone else to take your spot. If consent has been withdrawn by a substitute decision maker of an individual who resides in a congregate setting, then the congregate setting must contact the local public health unit.**

## Acknowledgement of Collection, Use and Disclosure of Personal Health Information

The personal health information on this form is being collected for the purpose of providing care to you and creating an immunization record for you, and because it is necessary for the administration of Ontario's COVID-19 vaccination program. This information will be used and disclosed for these purposes, as well as other purposes authorized and required by law. For example,

- it will be disclosed to the Chief Medical Officer of Health and Ontario public health units where the disclosure is necessary for a purpose of the *Health Protection and Promotion Act*.  
And
- it may be disclosed, as part of your provincial electronic health record, to health care providers who are providing care to you.

The information will be stored in a health record system under the custody and control of the Ministry of Health.

Where a Clinic Site is administered by a hospital, the hospital will collect, use and disclose your information as an agent of the Ministry of Health.

**I acknowledge that I have read and understand the above statement.**

You may be contacted by a hospital, local public health unit, or the Ministry of Health for purposes related to the COVID-19 vaccine (for example, to remind you of follow up appointments and to provide you with a record of immunization). If you consent to receiving these follow up communications by email, please indicate this using the box below.

**I consent to receiving follow-up communications:**

**by email**       **by text/SMS**

If you agreed to be contacted by email or text/SMS, please provide your email address or your text/SMS number: \_\_\_\_\_

### **Consent to Being Contacted About Research Studies**

You have the option of consenting to be contacted by researchers about participation in COVID-19 vaccine related research studies. If you consent to be contacted, your personal health information will be used to determine which studies may be relevant to you, and your name and contact information will be disclosed to researchers. Consenting to be contacted about research studies does not mean you have consented to participate in the research itself. Participating in research is voluntary. You may refuse to consent to be contacted about research studies without impacting your eligibility to receive the COVID-19 vaccine.

If you do not wish to be contacted about research studies, please indicate this below.

If you consent to be contacted about research studies, and then change your mind, you may withdraw consent at any time by contacting the Ministry of Health at [vaccine@ontario.ca](mailto:vaccine@ontario.ca).

This will not impact your eligibility to receive the Covid-19 vaccine.

**I consent to be contacted about COVID-19 vaccine related research studies:**

**by email**     **by text/SMS**     **by phone**     **by mail**

**If selected by email, please provide your email address: \_\_\_\_\_**

**I do not consent to be contacted about COVID-19 related research studies:**

Signature	Print Name	Date of Signature

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If signing for someone other than yourself, indicate your relationship to that other person:

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If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker.

***Specific Issues re: Long-Term Care Homes Act, 2007***

The resident's consent to receive the vaccine may be withdrawn or revoked at any time.

**Statement respecting section 83 of the Act:**

Please note the following legal protection:

Every licensee of a long-term care home shall ensure that no person is told or led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because,

- a) a document has not been signed;
- b) an agreement has been voided; or
- c) a consent or directive with respect to treatment or care has been given, not given, withdrawn or revoked.

FOR CLINIC USE ONLY					
Agent	COVID-19	Product Name	Lot #		Dose Amount:
Anatomical Site	<input type="checkbox"/> Left deltoid <input type="checkbox"/> Right deltoid		Route	Intramuscular (IM)	Dose #:
Date Given	----- / ----- / ----- (m/d/yyyy)	Time Given	----- : ----- am pm	AEFI? (after receiving current dose)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Given By (Name, Designation)		Location	Authorized By
Reason for Immunization	<input type="checkbox"/> Healthcare Worker <input type="checkbox"/> LTC: Resident <input type="checkbox"/> LTC: Healthcare Worker <input type="checkbox"/> LTC: Other Non- Employee <input type="checkbox"/> RH: Healthcare Worker <input type="checkbox"/> RH: Resident <input type="checkbox"/> RH: Essential Caregiver <input type="checkbox"/> RH: Other Non-Employee <input type="checkbox"/> Advanced Age: Community Dwelling <input type="checkbox"/> Adult of Chronic Health Care <input type="checkbox"/> Indigenous community <input type="checkbox"/> Other Priority Population <input type="checkbox"/> Congregate Living: Resident <input type="checkbox"/> Congregate Living: Staff <input type="checkbox"/> Congregate Living: Essential Caregiver		
Reason Immunization Not Given	<input type="checkbox"/> Immunization is contraindicated <input type="checkbox"/> Practitioner recommends immunization but no PATIENT consent <input type="checkbox"/> Practitioner decision to temporarily defer immunization <input type="checkbox"/> Medically Ineligible <input type="checkbox"/> Patient withdrew consent for series		
Your next dose is scheduled for:	----- / ----- / ----- (m/d/yyyy) ----- : ----- am pm		