Ontario

Ministry of Health

COVID-19 Vaccine Consent Form

CONSENT FORM – Pfizer-BioNTech COVID-19 Vaccine

Version 1 - December 12, 2020

Last name: ___________________________**First name**: __________________________

Identification (e.g. Health card number): ______________________________________

Home Phone: ______________________ **Mobile Phone:** ___________________________

Email address: ____

Street Address: __________________ **City:** ___________**Postal Code**: ______________

Date of Birth: Year________ **Month** ________ **Day** ________ **Age:** ________

Primary Care Clinician (Family Physician or Nurse Practitioner): ____________________

Is this **your first or second dose** of the vaccine? First ☐ Second ☐

If second, please indicate date of the first dose: _____/_____/_____ (month, day, year)

Please answer all questions below:

Do you have symptoms of COVID-19, for example fever, new onset of cough or worsening of chronic cough, shortness of breath, difficulty breathing, sore throat, difficulty swallowing, decrease or loss of smell or taste, chills, headaches, unexplained tiredness/malaise/muscle aches, nausea/vomiting, diarrhea or abdominal pain, pink eye, or runny nose or nasal congestion without other known cause?	No ☐ Yes ☐ If yes, please provide details

• **If you are over 70 years of age, have you experienced an unexplained or increased number of falls, acute functional decline, worsening of chronic conditions or delirium?**	
Are you immunosuppressed due to disease or treatment, or do you have an autoimmune disorder?	No ☐ Yes ☐ If yes, please provide details
Have you previously had an allergic reaction to any vaccine or any component of the Pfizer-BioNTech vaccine?	No ☐ Yes ☐ If yes, please provide details
Are you or could you be pregnant?	No ☐ Yes ☐ If yes, please provide details
Are you breastfeeding?	No ☐ Yes ☐ If yes, please provide details
Do you have a bleeding disorder or are taking medications that could affect blood clotting?	No ☐ Yes ☐ If yes, please provide details
Are you taking any medication that could affect blood clotting (e.g. blood thinners)?	No ☐ Yes ☐ If yes, please provide details
Have you ever felt faint after a past vaccination or medical procedure?	No ☐ Yes ☐ If yes, please provide details
Are you allergic to polyethylene glycol which is contained in the vaccine? It can be found in some products such as cosmetics, skin care products, laxatives, cough syrups, bowel preparation products for colonoscopy, and some foods and drinks.	No ☐ Yes ☐ Uncertain ☐ If yes, please provide details

Tell the health care provider if you are allergic to anything that may contain polyethylene glycol.	
Have you received another vaccine (not a COVID-19 vaccine) in the past 14 days?	No ☐ Yes ☐ If yes, please provide details

I have read (or it has been read to me) and I understand the "COVID-19 Vaccine Information Sheet - Pfizer / BioNTech COVID-19 Vaccine". I have had the opportunity to ask questions and to have them answered to my satisfaction. I consent to receiving the vaccine.

Signature: ______________________ Print: ______________________

Date of signature: ______________________

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

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