Ministry of Health

Ontario

COVID-19 Vaccine Consent Form

CONSENT FORM – Pfizer-BioNTech COVID-19 Vaccine

Version 1.1 – December 14, 2020

Last Name	First Name	Identification (e.g., health card number)

Home Phone	Mobile Phone	Email Address	Primary Care Clinician (Family Physician or Nurse Practitioner)

Street Address	City	Province	Postal Code

Date of Birth (month, day, year) _____ / _____ / _____	Age	Is this your **first or second dose** of the vaccine? ☐ First ☐ Second If second, please indicate the 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? 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? ☐ No ☐ Yes	If yes, please provide details
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 (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. Tell the health care provider if you are allergic to anything that may contain polyethylene glycol. ☐ No ☐ Yes ☐ Uncertain	If yes, please provide details
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	**The personal health information on this form is being collected for the purpose of providing care to you. It will be used and disclosed for this purpose, 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*.** ☐ I acknowledge that I have read and understand the above statement.	**The hospital, local public health units and the Ministry of Health may wish to communicate with you for purposes related to the COVID-19 vaccine (for example, communications to remind you of follow-up appointments, to provide you with proof of vaccination, and to tell you about research projects.)** I consent to receiving communications by: ☐ email ☐ phone/SMS

Signature	Print Name	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.

FOR CLINIC USE ONLY

Agent	COVID-19	Product Name	COVID-19 Pfizer Vaccine Pfiz.
Dose	0.3 ml	Lot Number	EK4175
Anatomical Site	☐ Left deltoid ☐ Right deltoid	Route	Intramuscular

Dose Number	1 of 2
Date / Time Given	_____ / _____ / _____ (month, day, year) _____ : _____ am pm
Reason for Immunization	Healthcare worker: ☐ LTC Home ☐ Retirement Home ☐ Other
Reason Immunization Not Given	Healthcare provider: ☐ Determines immunization is contraindicated ☐ Recommends imms but no consent received
Adverse Event After Immunization?	☐ Yes ☐ No
Location	_____
Given By (Name, Designation)	_____ , _____
Authorized By	_____
Your dose 2 of 2 is scheduled for	_____ / _____ / _____ (month, day, year) _____ : _____ am pm