LEEDS PHARMACY
163 Ormond st, Brockville, ON
Tel 613-865-8885
WWW.Leedspharmacy.ca

Covid-19 Vaccine Consent Form 2024/2025

Patient Information		
First Name:	**Last Name:**	
Date of Birth: (dd / mm / yyyy):		**Age:**
Address:		
Health Card #:	**Telephone Number:**	
Emergency Contact Name and Telephone Number:		

Screening Questionnaire for Person to be Vaccinated	Yes	No
Has it been at least 6 months since your last dose of COVID Vaccine? (your last COVID vaccine must be more than 6 months ago)		
Do you or have you had a fever within the past 2 weeks? (i.e., fever greater than 38.0°C, breathing problems, active infection)?		
Have you had a serious reaction to a vaccine in the past?		
Have you had a severe (i.e. anaphylaxis) allergic reaction to polyethylene glycol (PEG)?**		
Do you have an allergy to any of the components of the vaccine? *(polyethylene glycol (PEG) , polysorbate , Tromethamine)*		
Do you take a blood thinner or have a bleeding disorder?		
Do you have a new or changing condition affecting the brain or nervous system?		
Have you ever had Guillain-Barré syndome?		
Do you have any autoimmune conditions?		

Covid 19 Vaccination Patient/Agent Consent:

I have read or had explained to me and understand the information about the covid vaccine as outlined on the Fact Sheet. I have had a chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the covid-19 vaccine. I agree to wait in the pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the vaccine

I confirm that I want to receive the COVID-19 vaccine

Name : _____ Signature _____ Date: _____

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 have the legal authority to provide consent for the individual that is to receive the COVID-19 vaccine (i.e. you are a parent, legal guardian, or substitute decision maker)

** PEG can rarely cause allergic reactions and is found in products such as cosmetics, skin care products, laxatives, cough syrups and bowel preparation products for colonoscopy.

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

The personal health information on this form is collected for the purpose of providing care and creating an immunization record and is necessary for the administration of Ontario's covid 19 vaccination program. The information will be used and disclosed for these purposes and other purposes as required by law. For example, disclosure to the Chief Medical Officer of Health and the Public Health Unit where disclosure is necessary for Health Protection and Promotion Act. It may also be disclosed as part of your electronic health record to other healthcare providers who are providing care to you. The information is stored in a health record system under the custody and control of the Ministry of Health. 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. Ministry of Health Version 6.1 – October 6, 2022 2 • It may be disclosed, as part of your provincial electronic health record, to health care providers who are providing care to you. I understand that I may restrict the disclosure of my personal health information for treatment purposes at any time by emailing vaccine@ontario.ca.

I acknowledge that I have read and understand the above statement. Inital: _____

Immunization Record

Patient Name :

Date of administration: / /	**Time of administration:** AM / PM

Pharmacist Documentation - Pharmacy use only

☐ **Moderna Spikevax XBB DIN: 02541270** **Lot #: AW3263B Exp: 11/03/2025** ☐ **Adult Dose: 0.5 ML** ☐ **6-11 Yrs old: 0.25 ML**	☐ **Comirnaty Pfizer DIN: 2541823** **Lot #: LN2588 Exp: 1/2026 Grey cap** **12 years of age and older only** **dose : 0.3 mL** **use 1 ML syringe with 5/8 needle**	**Route of administration : IM** **Site: Deltoid** ☐ **Left** ☐ **Right**

I confirm that the Covid-19 Vaccine was to the patient above based on my assessment and his/her consent.

Administering Healthcare provider Name :

☐ Tamer Badawy (OCP # 605149)

☐ Threse Guirguis (OCP # 615717)

☐ Emile Diab (OCP. Lic# 629376)

☐ Kylee McNamara (OCP # 629213)

Signature _____