# Consent for COVID-19 vaccine - children, youth and adults

## Section 1 Personal Information

| Last name | | First name | Medicare number | | |
|---|---|---|---|---|---|
| | | | | | |
| Home phone | Mobile phone | Email | | | |
| | | | | | |
| Street address | | | City | Province | Postal code |
| | | | | | |

| D.O.B (YYYY/MM/DD) | Gender | Is this your first, second, third or booster dose of the vaccine? |
|---|---|---|
| | ☐ Male ☐ Female ☐ Other | ☐ 1st ☐ 2nd ☐ 3rd (immunocompromised) ☐ 4th (immuncompromised<br>☐ Booster What is the date of your most recent dose? (YYYY/MM/DD) |

**Check all applicable**

☐ Health care worker ☐ Long-term care residents ☐ Indigenous - First Nations community member

If you are a health care worker, please indicate on the right: ☐ Vitalité Health Network ☐ Horizon Health Network ☐ EM/ANB ☐ Private practice ☐ Other (specify)

**To be completed by the clinic staff** Clinic location / Site information (*where the client receives their vaccine)

## Section 2 Health information for the person being immunized (If you need more space, use the other side of this form.)

***Immunizers: please review relevant vaccine information sheet(s) with the person being immunized.**

☐ No ☐ Yes ☐ N/A — Has this person ever had a COVID-19 infection? If yes, please indicate when the symptoms started or date of positive test results and describe any treatments received (monoclonal antibodies or convalescent plasma)

☐ No ☐ Yes ☐ N/A — Is this person feeling ill today or has any symptoms of COVID-19?

☐ No ☐ Yes ☐ N/A — Does this person have any allergies, including allergies to any components of the vaccine [including tromethamine, polysorbate 80 or polyethylene glycol (PEG)] or to medication given by injection or intravenously in the past?
If yes, describe

☐ No ☐ Yes ☐ N/A — Does this person have any conditions or problems with their immune system, diagnosed with an auto-immune condition or taking medication or IV infusions which affects the immune system? (List all if more than one)
If yes, describe

☐ No ☐ Yes ☐ N/A — Is this person taking any medicine, like anticoagulants (blood thinner) or have a bleeding disorder?
If yes, describe

☐ No ☐ Yes ☐ N/A — Has this person been diagnosed with blood clots with low platelets after a COVID-19 vaccine or has a history of blood clot in the brain (cerebral venous sinus thrombosis) or low platelets (thrombocytopenia) or heparin-induced thrombocytopenia (HIT)?

☐ No ☐ Yes ☐ N/A — Has this person ever been diagnosed with a condition known as Capilliary Leaking Syndrome ?

☐ No ☐ Yes ☐ N/A — Is this person pregnant? ☐ No ☐ Yes Is this person breastfeeding?

☐ No ☐ Yes ☐ N/A — Has this person ever had a serious side effect from other non-covid vaccines or to a previous dose of a COVID-19 vaccine including myocarditis and / or pericarditis (following either Pfizer Cominarty or Moderna)
If yes, describe

☐ No ☐ Yes ☐ N/A — Has this person ever felt faint or fainted after a past vaccination or medical procedure?

☐ No ☐ Yes ☐ N/A — Where applicable, for immunocompromised individuals eligible to receive a third dose, has this person filled out an attestation form?

☐ No ☐ Yes ☐ N/A — Has the child had a condition known as MIS-C (Multisystem Inflammatory Syndrome)? Vaccination should be postponed until clinical recovery has been achieved or until it has been ≥ 90 days since diagnosis, whichever is longer.

☐ No ☐ Yes ☐ N/A — Has the child received another vaccine in the past 14 days? If yes, the COVID-19 vaccine should not be given concomitantly with other vaccines (live or non-live). The minimum waiting period between vaccines is 14 days.

Should you decide to provide all of the information requested on the form, it is important to know that its submission constitutes consent to the collection, use and disclosure of your personal information.

The collection use and disclosure of personal information is protected by the *Right to Information and Protection of Privacy Act* (RTIPPA), *Personal Health Information Privacy and Access Act* (PHIPAA) and all other applicable legislation, regulation or policy.

If you wish to know more about your privacy rights, please consult:
gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/HealthActs/PrivacyNotice.pdf



13505 (2021/12/17)

New Nouveau Brunswick

## Section 3 Consent

**For all doses of the COVID-19 vaccine, your consent will confirm the following:**

- I have read the information I was given on the COVID-19 vaccine being offered to me today and consent to have administered the two required doses, and an additional third dose based on Public Health recommendations.
- I understand the benefits and possible reaction(s) for the COVID-19 vaccine and the risk of not being immunized.
- I have had an opportunity to discuss my questions and concerns as they relate to the COVID-19 vaccine.
- I understand that I may withdraw this consent at any time by informing the health care 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 | | Signature of person giving consent | | Date (YYYY/MM/DD) |
|---|---|---|---|---|

Relationship to person giving consent: ☐ Parent (with legal authority to consent) ☐ Guardian/Legal representative

| Note: This section is for office use and to be used only for immunizations given to **INDIVIDUALS AGED 12 AND OVER** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Please check the dose and circle the vaccine being given: ☐ 1st ☐ 2nd ☐ 3rd ☐ booster | Lot #<br>Date of exp. | Site | Route | Dosage (ml) | Date (YYYY/MM/DD) | Time | Print name and signature of immunizer |
| Moderna Spikevax AstraZeneca<br>Pfizer-BioNTech Comirnaty Janssen | | ☐ Right arm<br>☐ Left arm | ☐ IM | ml | | | |

| Note: This section is for office use, and to be used only for immunizations given to **INDIVIDUALS AGED 5 TO 11 YEARS OLD ONLY** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Please check the pediatric dose of the vaccine being given: ☐ 1st ☐ 2nd | Lot #<br>Date of exp. | Site | Route | Dosage (ml) | Date (YYYY/MM/DD) | Time | Print name and signature of immunizer |
| Pfizer-BioNTech Comirnaty | | ☐ Right arm<br>☐ Left arm | ☐ IM | 0.2 ml | | | |

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