COVID-19 Vaccine Screening and Consent Form

Vaccine Recipient Information			
Name: (Last, First)		**Date of Birth: (MM-DD-YY)**	
Address:		**Health Services Number:**	
Phone Number:		**Sex: ☐ Male ☐ Female ☐ Other**	
Emergency Contact Information **Name:**		**Phone Number:**	
Do you work in a healthcare facility? ☐ Yes ☐ No **If yes, what type: ☐ SHA ☐ SHA LTC ☐ non-SHA ☐ non-SHA LTC ☐ PCH** **(SHA=Saskatchewan Health Authority; LTC= long-term care; PCH=personal care home)**			
Screening			
The following questions will help determine if a vaccine is right for you. A "yes" to any question does not necessarily mean you should not be vaccinated, but your pharmacist may have some additional questions.			
1. Have you received any **previous COVID-19 vaccine**?		**☐ Yes**	**☐ No**
2. Have you had a **previous COVID-19 infection**?		**☐ Yes**	**☐ No**
2a. If yes to Question 2, were you treated with **convalescent plasma** or **monoclonal antibodies**?		**☐ Yes** **☐ Don't know**	**☐ No**
3. Do you have any **severe allergies** such as anaphylaxis (e.g. difficulties breathing, itching/swelling of mouth or throat, hives, feeling faint, persistent vomiting/diarrhea) to any medication(s), vaccine(s) or food(s) or from an unknown cause? If yes, please describe:		**☐ Yes**	**☐ No**
4. Are you **pregnant,** could you be pregnant or are you planning on becoming pregnant before receiving both doses of the vaccine?		**☐ Yes**	**☐ No**
5. Are you **nursing/breastfeeding**?		**☐ Yes**	**☐ No**
6. Do you have an **autoimmune disorder**? (examples: Crohn's disease, lupus, multiple sclerosis, psoriasis, rheumatoid arthritis, type 1 diabetes)		**☐ Yes**	**☐ No**
7. Are you **immunosuppressed** or immunocompromised due to treatment/disease? ☐ **Medications** that affect immune system such as prednisone, other steroids, anticancer medications, transplant medications, medications used to treat inflammatory conditions (examples: Crohn's disease, psoriasis, rheumatoid arthritis). If unsure, ask your pharmacist. ☐ **Cancer** ☐ **Transplant** ☐ **HIV**		**☐ Yes**	**☐ No**
8. Do you have a **bleeding disorder** that makes you bleed easier or are you **taking blood thinners** (examples: Aspirin, warfarin, Eliquis®, Lixiana®, Pradaxa®, Xarelto®)		**☐ Yes**	**☐ No**
9. Do you have a history of • **heparin-induced thrombocytopenia (HIT),** or • **thrombosis associated with lupus anticoagulant** (**thrombotic antiphospholipid syndrome**), or • **cerebral venous sinus thrombosis (CVST) with thrombocytopenia**?		**☐ Yes**	**☐ No**
10. Have you received **any other vaccines** in the past 14 days?		**☐ Yes**	**☐ No**

Assessing Pharmacist (Name):

Vaccine Providers: see the accompanying Guide for interpretation of responses

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Declaration of Consent:

- I have read or had explained to me the vaccine information sheet regarding the risks, benefits and potential side effects associated with the vaccine.
- I have had the opportunity to have my questions answered by the pharmacist.
- I understand the information I have been given.
- I understand the need for observation by the vaccine provider for 15 minutes after my vaccination.
- I understand health information may be shared with another healthcare provider as necessary for care**.**
- I consent to the vaccine provider administering the vaccine for myself or my child /dependent.

_____ _____

Signature of: ☐ Vaccine Recipient ☐ Parent /Guardian ☐ Proxy **Date**

_____

Name (if not signed by vaccine recipient)

For Pharmacy Use Only

Vaccine recipients who work in healthcare facilities must be entered into the Vaccine Risk Factor Portal before entering the prescription and billing to DPEBB. Healthcare Worker type(s) (if applicable):

☐ SHA ☐ SHA LTC ☐ non-SHA ☐ non-SHA LTC ☐ PCH

(SHA=Saskatchewan Health Authority; LTC= long-term care; PCH=personal care home)

Vaccine Details

Vaccine Name: ☐ Age Appropriate?	Manufacturer:	DIN:	Lot #:	Expiry Date:

Vaccine Preparation

Vaccine Drawn by (Name):	Date & Time Vaccine Drawn:

Vaccine Administration

Dosage:	Site:	Route:	Dose #:	Vaccine Administered by (Name):	Date & Time of Injection:

Adverse reaction: ☐ No ☐ Yes – describe reaction below

☐ Completed Adverse Event Following Immunization (AEFI) form

(See https://formulary.drugplan.ehealthsask.ca/COVIDImmunizationProgram, Section 9 for form and reporting instructions.)

Vaccine Name	Manufacturer	DIN	Dosage
AstraZeneca COVID-19 Vaccine (**8** doses per vial)	AST	02511444	0.5 mL
AstraZeneca COVID-19 Vaccine (**10** doses per vial)	AST	02510847	0.5 mL
COVISHIELD	Verity	02512947	0.5 mL
Janssen COVID-19 Vaccine	JAN	02513153	0.5 mL
Moderna COVID-19 Vaccine	Moderna	02510014	0.5 mL
Pfizer-BioNTech COVID-19 Vaccine (PFI)	PFI	02509210	0.3 mL

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