Consent for COVID-19 vaccine - All individuals aged 6 months and over

☐ The demographic and vaccine administration information included in this form was verified and validated by a second clinician (other than the immunizer) at the immunization site to ensure and document the completeness and accuracy of all Immunization Records. This validation (double check) must be done and documented prior to sending (for entry) or entering the information. All completed paper administration forms need to be sent via Canada Post Xpress post which is considered a secure method of delivery. These forms must be placed in an envelope, seal the flap and write initials on the flap. Then mail the envelopes to:

C/O Data Entry Team
GNB Department of Health HSBC Place
520 King Street, 4th Floor Reception Fredericton, NB E3B 5G8

Each time you mail an envelope, you must send an email to Phisisp@gnb.ca notifying them that an envelope has been sent and provide the following information:

· # of admin forms in envelope
· Tracking number for envelope

The data entry team will send a reply to you when the envelope has been received. Forms can be faxed to 1-833-415-1830.
Note: These administration forms do not need to be completed for COVID-19 vaccines administered by Pharmacists entering the immunization information in the Drug Information System (DIS) or by Physicians/Nurse Practitioners who submit billing to medicare.

Section 1 Personal Information

Last name	First name	Medicare number	D.O.B (YYYY/MM/DD)

Home phone	Mobile phone	Email

Street address	City	Province	Postal code

Gender
☐ Male ☐ Female
☐ Other

Is this your first, second or 3rd (for immunocompromised) primary series dose?
Primary dose series: ☐ 1st ☐ 2nd ☐ 3rd
Booster dose series: ☐
Date of your most recent dose? (YYYY/MM/DD)

Children aged between 5-11 who previously received a monovalent booster must wait 5 months before getting their bivalent booster

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. _____ (YYYY/MM/DD)
After a COVID-19 infection, wait 8 weeks to start or complete a primary series and 4 weeks for individuals considered moderately to severely immunocompromised. If you are booking a booster dose, the wait time is 5 months from either your last vaccine dose OR the date of your COVID-19 infection (whichever is more recent)

☐ No ☐ Yes ☐ N/A Has this person ever received any treatments related to a COVID-19 vaccine infection such as monoclonal antibodies or convalescent plasma?" If yes, please indicate the date the treatment was given: _____ (YYYY/MM/DD)
It is recommended that COVID-19 vaccines should not be given while receiving monoclonal antibodies(ex: Evusheld) or convalescent plasma. Consult with a health care provider.

☐ No ☐ Yes ☐ N/A Is this person feeling ill today or has any symptoms of COVID-19?
It is recommended that symptoms of acute illness should be resolved and no longer contagious prior to vaccination.

☐ No ☐ Yes ☐ N/A Has this person ever had a serious reactions to a previous vaccine (including non-covid) or to any components of the vaccine (e.g.: tromethamine, polysorbate 80 or polyethylene glycol [PEG], kanamycin, carbenicillin) or to medication given by injection or intravenously in the past?
If yes, please describe
Depending on the allergy, it is possible to receive a COVID vaccine. You may be asked to wait longer in the clinic after receiving the vaccine.

☐ No ☐ Yes ☐ N/A Does this person have any conditions or problems with their immune system, been diagnosed with an auto-immune condition or is taking medication or IV infusions which affects the immune system?
Additional doses may be needed as a result of your immune system's response to the vaccine. Consult with your health care provider.

☐ No ☐ Yes ☐ N/A Is this person taking any medicine, like anticoagulants (blood thinners) or have a bleeding disorder?
Individuals may be safely immunized without discontinuation of their anticoagulation therapy.

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Last name		First name	

☐ No ☐ Yes ☐ N/A Has this person been diagnosed with any of the following blood clot conditions: Immune thrombocytopenia (ITP), Venous thromboembolism (VTE), Thrombosis with thrombocytopenia syndrome (TTS) following vaccination or Capilliary Leaking Syndrome (CLS)? If yes, describe the recommendations advised by your health care provider.
Individuals with previous TTS or CLS should not receive further viral vector vaccines. For any of the conditions, mRNA vaccines are preferred and a consultation with a health care provider should have occured. These individuals should not receive a subsequent dose of a viral vector COVID-19 vaccine.

☐ No ☐ Yes ☐ N/A Is this person pregnant? ☐ No ☐ Yes Is this person breastfeeding?
Pregnancy puts you at higher risk of COVID-19 complications. There are no indicated safety concerns for pregnant and breastfeeding individuals. mRNA vaccines are safe and preferred.

☐ No ☐ Yes ☐ N/A Has this person ever suffered from inflammation of the heart or lining of the outside of the heart (myocarditis/pericarditis) after a previous dose of a COVID-19 vaccine.
If yes, describe the recommendations given by your health care provider.
It is possible to receive an mRNA vaccine after a history of myocarditis or pericarditis. A consultation with a health care provider should have occured.

☐ 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 this person received Tuberculin skin testing (TST) or interferon gamma release assay (IGRA) test recently?
Vaccination can occur at any time before, after or same time as the TST or IGRA test. Repeat testing is recommended at least 4 weeks post immunization.

☐ No ☐ Yes ☐ N/A Has this person received other non-COVID vaccine (live or non-live) in the past 14 days?
Co-administration between vaccine products can now occur at any age when administering COVID-19 vaccines.

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

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 recommended 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 dose: ☐	Lot # Date of exp.	Site	Route	Dosage (ml)	Date (YYYY/MM/DD)	Time	Print name and signature of immunizer
*Moderna Spikevax Bivalent BA.4/BA.5 *Pfizer Comirnaty Bivalent BA.4/BA.5		☐ Right arm ☐ Left arm	☐ IM				

Note: This section is for office use, and to be used only for **IMMUNIZATIONS GIVEN TO INDIVIDUALS AGED 5 TO 11 YEARS OLD**

Please check the pediatric dose of the vaccine being given: ☐ 1st ☐ 2nd ☐ **3rd *Booster dose: ☐	Lot # Date of exp.	Site	Route	Dosage (ml)	Date (YYYY/MM/DD)	Time	Print name and signature of immunizer
* Pfizer Comirnaty Bivalent BA.4/5		☐ Right arm ☐ Left arm	☐ IM				

Note: This section is for office use, and to be used only for **PRIMARY SERIES DOSES GIVEN FOR INDIVIDUALS AGED 6 MONTHS TO 4 YEARS AND 11 MONTHS OLD**

Please check the pediatric dose of the vaccine being given: ☐ 1st ☐ 2nd ☐ 3rd **4th	Lot # Date of exp.	Site	Route	Dosage (ml)	Date (YYYY/MM/DD)	Time	Print name and signature of immunizer
Pfizer Comirnaty infant		☐ Right arm ☐ Left arm ☐ Right thigh ☐ Left thigh	☐ IM				

*** Depending on the purpose of the vaccine being given (i.e. given as a booster dose or as a primary series dose) the dosages may differ. Health Care Professionals are to double check the appropriate dosage of the product before administration.**
**** For immunocompromised individuals needing an additional dose.**

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

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