Yukon

CONSENT FOR IMMUNIZATIONS ASTRAZENECA/COVISHIELD COVID-19

Section 1: Personal information			
Last name	First name		
Health card #	Date of birth YYYY/MM/DD		Age
Street address	City	Terr./prov.	Postal code
Phone number	Email		

Section 2: Consent	
Are you under the age of 55? • If yes, **VACCINATION IS CONTRAINDICTED.**	☐ Yes ☐ No
Do you have any allergies?	☐ Yes ☐ No
• **If yes**, do you have a known allergy to polysorbates[1]? (Polysorbate 80 is contained in the AstraZeneca/Covishield vaccine)	☐ Yes ☐ No
• If yes, **VACCINATION IS CONTRAINDICTED.**	
• **If yes**, have you had anaphylaxis or severe allergy from an unknown cause?	☐ Yes ☐ No
• If yes, consider referral to specialist prior to immunization.	
Are you feeling ill today? • If yes, consider deferral.	☐ Yes ☐ No
Are you or could you be pregnant?	☐ Yes ☐ No
Are you breastfeeding?	☐ Yes ☐ No
Do you have any problems with your immune system or are you taking any medications that can affect your immune system? (e.g., high dose steroids, chemotherapy) • If yes, provide details.	☐ Yes ☐ No
Do you have an autoimmune disease? • If yes, provide details.	☐ Yes ☐ No
If this is your second dose of the COVID vaccine, did you have any side effects after the first dose? • If yes, provide details.	☐ Yes ☐ No
Have you received another vaccine (not a COVID-19 vaccine) in the past 14 days? • If yes, **DEFER VACCINATION.**	☐ Yes ☐ No

[1]Polysorbates are found in other medications (e.g., vaccines, vitamins, oils, anticancer treatment and medication tablets), and some creams and ointments.

Do you have a bleeding disorder or are you taking any medications that could affect blood clotting? • If unsure, ask the health care provider about your medical conditions. • If yes, provide details, **DEFER VACCINATION** until consultation with HCP.	☐ Yes ☐ No

I have read (or it has been read to me) and I understand the *AstraZeneca/Coivshield COVID-19 Vaccine* information sheet. I have had the opportunity to ask questions and to have them answered to my satisfaction. I consent to the receiving the AstraZeneca/Covishield vaccine.

I understand this consent is valid for both doses of the AstraZeneca/Covishield COVID-19 vaccine, unless the consent is cancelled.

☐ I do consent ☐ I do not consent

_____	_____	_____
Signature	Print name	Date of signature

If signing for someone other than yourself, indicate your relationship to that other person:

_____

☐ I confirm that I am the parent / legal guardian or substitute decision maker.

Comments:

Yukon

CONSENT FOR IMMUNIZATIONS
COVID-19 VACCINE
LONG-TERM CARE RESIDENTS

Section 1: Personal information

Last name		First name	Date of birth YYYY/MM/DD
☐ Male ☐ Female	Health card #	Name of long term care home	House/Unit
Name of person consenting on behalf of resident (if applicable)		Relationship to resident	Phone number

Alert: Are you aware if the person you are providing consent for has ever had a seriouerious or life threatening allergic reaction? ☐ Yes ☐ No

Allergies (list below):

Section 2: Consent

For the COVID-19 vaccine listed below, check yes or no, sign and date.

I have reviewed the COVID-19 vaccine information sheet "COVID-19 Vaccine Information Sheet – Moderna COVID-19 Vaccine (mRNA-1273 SARS-CoV-2 Vaccine)" with the above named SDM.	☐ Yes	☐ No
I have provided the opportunity for them to ask questions	☐ Yes	☐ No
The above mentioned SDM has provided verbal consent.	☐ Yes	☐ No
The SDM understand that this consent is valid for the COVID-19 vaccine, **for both doses of the vaccine**, unless the consent is cancelled.	☐ Yes	☐ No

Moderna COVID-19 Vaccine (mRNA-1273 SARS-CoV-2 Vaccine)

☐ SDM consents ☐ SDM does not consent	☐ Documented in Gold Care	
Nurse signature	Nurse print name	Date YYYY/MM/DD

Information contained in this form is collected, used and disclosed in accordance with Yukon's *Health Information Privacy and Management Act* and other applicable laws. A written statement of Health and Social Services information practices can viewed at www.hss.gov.yk.ca/healthprivacy.php or by contacting the department's privacy officer at healthprivacy@gov.yk.ca.

Yukon

CONSENT FOR IMMUNIZATIONS
mRNA COVID-19 VACCINE

Section 1: Personal information			
Last name	First name	Date of birth YYYY/MM/DD	☐ Male ☐ Female
Name of person consenting on behalf of client (if applicable)		Health card #	
Street address	City	Prov./Terr.	Postal code
Day phone	Cell phone		
Alert: Have you ever had a serious or life threatening allergic reaction? ☐ Yes ☐ No	**Allergies:** Have you had any previous reaction to immunization? ☐ Yes ☐ No		
Chronic condition			

Section 2: Consent

For the COVID-19 vaccine listed below, check yes or no, sign and date.

I have read (or it has been read to me) and I understand the "mRNA COVID-19 vaccine information sheet".

I have had the opportunity to ask questions and to have them answered to my satisfaction.

I consent to receiving the vaccine.

I understand this consent is valid for the COVID-19 vaccine, **for both doses of the vaccine**, unless the consent is cancelled.

Moderna COVID-19 Vaccine (mRNA-1273 SARS-CoV-2 Vaccine)		
I want to be immunized. ☐ I do consent ☐ I do not consent	Signature	Date YYYY/MM/DD
Pfizer - BioNTech Vaccine (BNT162b2 SARS-CoV-2)		
I want to be immunized. ☐ I do consent ☐ I do not consent	Signature	Date YYYY/MM/DD

If signing for someone other than yourself, indicate your relationship to that other person

☐ I confirm that I am the parent, legal guardian or substitute decision maker.

IMMUNIZER USE ONLY	
Telephone consent obtained from	Nurse's signature
Relationship to client	Date

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Yukon

CONSENT FOR IMMUNIZATIONS
JANSSEN COVID-19

Section 1: Personal information			
Last name	First name		
Health card #	Date of birth YYYY/MM/DD		Age
Street address	City	Terr./prov.	Postal code
Phone number	Email		

Section 2: Consent	
Are you under the age of 18? • If yes, **VACCINATION IS CONTRAINDICTED.**	☐ Yes ☐ No
Do you have any allergies?	☐ Yes ☐ No
• **If yes**, do you have a known allergy to polysorbates[1]? (Polysorbate 80 is contained in the Janssen vaccine) • If yes, **VACCINATION IS CONTRAINDICTED.**	☐ Yes ☐ No
• **If yes**, have you had anaphylaxis or severe allergy from an unknown cause? • If yes, defer vaccination and consider referral to a specialist prior to immunization.	☐ Yes ☐ No
Are you feeling ill today? • If yes, consider deferral.	☐ Yes ☐ No
Are you or could you be pregnant?	☐ Yes ☐ No
Are you breastfeeding?	☐ Yes ☐ No
Do you have any problems with your immune system or are you taking any medications that can affect your immune system? (e.g., high dose steroids, chemotherapy) • If yes, provide details.	☐ Yes ☐ No
Do you have an autoimmune disease? • If yes, provide details.	☐ Yes ☐ No
If this is your second dose of the COVID vaccine, did you have any side effects after the first dose? • If yes, provide details.	☐ Yes ☐ No

[1]Polysorbates are found in other medications (e.g., vaccines, vitamins, oils, anticancer treatment and medication tablets), and some creams and ointments.

Do you have a bleeding disorder or are you taking any medications that could affect blood clotting? • If unsure, ask the health care provider about your medical conditions. • If yes, provide details, **DEFER VACCINATION** until consultation with HCP.	☐ Yes ☐ No

I have read (or it has been read to me) and I understand the *Janssen COVID-19 Vaccine* information sheet and after care sheet. I have had the opportunity to ask questions and to have them answered to my satisfaction. I consent to the receiving the Janssen vaccine.

☐ I do consent ☐ I do not consent

_____	_____	_____
Signature	Print name	Date of signature

If signing for someone other than yourself, indicate your relationship to that other person:

_____

☐ I confirm that I am the parent / legal guardian or substitute decision maker.

Comments:

Yukon

CONSENT FOR IMMUNIZATIONS
COVID-19 VACCINE

Section 1: Personal information			
Last name	First name	Date of birth YYYY/MM/DD	☐ Male ☐ Female
Name of person consenting on behalf of client (if applicable)		Health card #	
Street address	City	Prov./Terr.	Postal code
Day phone	Cell phone		
Alert: Have you ever had a serious or life threatening allergic reaction? ☐ Yes ☐ No	**Allergies:** Have you had any previous reaction to immunization? ☐ Yes ☐ No		
Chronic condition			

Section 2: Consent

For the COVID-19 vaccine listed below, check yes or no, sign and date.

I have read (or it has been read to me) and I understand the "COVID-19 Vaccine Information Sheet – Moderna COVID-19 Vaccine (mRNA-1273 SARS-CoV-2 Vaccine)".

I have had the opportunity to ask questions and to have them answered to my satisfaction.

I consent to receiving the vaccine.

I understand this consent is valid for the COVID-19 vaccine, **for both doses of the vaccine**, unless the consent is cancelled.

Moderna COVID-19 Vaccine (mRNA-1273 SARS-CoV-2 Vaccine)		
I want to be immunized. ☐ I do consent ☐ I do not consent	Signature	Date YYYY/MM/DD
If signing for someone other than yourself, indicate your relationship to that other person ☐ I confirm that I am the parent, legal guardian or substitute decision maker.		

IMMUNIZER USE ONLY	
Telephone consent obtained from	Nurse's signature
Relationship to client	Date

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