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 or live in a personal care home? ☐ Yes ☐ No **If yes, what type: ☐ SHA ☐ non-SHA ☐ SHA LTC ☐ non-SHA LTC ☐ PCH ☐ PCH Resident** **(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? (Assessor: if "yes", document on page 2) Any side effects after the first dose:		**☐ 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**	**☐ No** **☐ Don't know**
3. Do you have any **severe allergies** such as anaphylaxis (e.g. difficulties breathing, itchy/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** or • **venous or arterial thrombosis with thrombocytopenia following AstraZeneca, COVISHIELD vaccines?**		**☐ 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

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 or are residents of a PCH must be entered into the Vaccine Risk Factor Portal before entering the prescription and billing to DPEBB. Category (if applicable):

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

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

This Section Applies to Second Doses Only:

Name of First Dose Vaccine: **Date of First Dose:**

☐ 2nd dose same vaccine as 1st **☐ Minimum interval between 1st and 2nd doses met (See Guide Q1 for details)**

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 8 for form and reporting instructions.)

Vaccine Name	Manufacturer	DIN	Dose
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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