

CORNERSTONE PHARMACY

ALBERTA COVID-19 PHARMACY IMMUNIZATION PROGRAM CONSENT & SCREENING FORM

Personal Information for the person being immunized		
Name (Last, First, Middle)	Date of Birth (dd-mm-yy)	
Personal Health Number (PHN)	Emergency Contact Name & Phone #	
Health Information for the person being immunized		
Are you sick today? (i.e. fever greater than 39.5°C, breathing problems, or active infection)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any allergies, including allergies to latex, any vaccine, medicine, or food? If yes, please describe.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had a serious reaction to, or fainted after receiving any vaccine (including COVID) in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any chronic illness or take any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had lymph nodes removed from your arms or chest or had a mastectomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you received a vaccination in the last 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had a recent corticosteroid injection or are you on immunosuppressive medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you take blood thinning medications or do you have a bleeding disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Consent for Immunization		
<p>I confirm that I have read the COVID-19 vaccine information. I know about and understand the risks, benefits, and common side effects of this vaccine. Any questions I may have had about this person getting this vaccine have been answered by calling the local public health office or Health Link at 811.</p> <p>I understand the information I have been given.</p> <p>I understand this consent is for all doses of the vaccine.</p> <p>I will contact the local public health office or the healthcare provider giving the COVID-19 vaccine if the person being immunized:</p> <ul style="list-style-type: none"> • has any changes to their health before getting any dose of the COVID-19 vaccine • gets another vaccine in the 14 days before they get any dose of the COVID-19 vaccine • has a severe or unusual side effect after the first dose of the COVID-19 vaccine (other than the expected side effects listed on the COVID-19 vaccine information sheet provided) <p>I consent to this person getting the COVID-19 immunization.</p> <p>I understand that I may withdraw this consent at any time by calling the healthcare provider giving the COVID-19 vaccine.</p> <p>I confirm that I have the legal authority to consent to this immunization.</p>		
Printed name of person giving consent	Daytime Telephone Number	Alternate Telephone Number
Relationship to person being immunized (select one)		
Person being immunized	Parent (with legal authority to consent)	Guardian/Legal representative
Co-decision-maker	Specific decision-maker	Agent
Signature of person giving consent	Date (dd-mm-yy)	
Name of healthcare provider obtaining the consent	Signature of healthcare provider obtaining the consent	

----- BELOW LINE FOR PHARMACY USE ONLY- ADD NOTES ON REVERSE AS NEEDED -----

Check Box to Confirm Patient Identity Verified Check box to Confirm Vaccine/Drug to be administered Verified

Vaccine & DIN	Lot#	Exp Date	Manufacturer	Dosage	Site of Injection	Sequence <small>Dose#</small>	Time
Pfizer-BNT Covid-19 Vaccine DIN 02509210			Pfizer-BNT	0.3 mL	IM L / R Deltoid	1 2	

Written info and verbal counseling provided to patient

Additional Assessment Notes (if applicable) : _____

Monitoring Post-Injection: Well Tolerated Reaction? : No Yes _____

Signature of Immunizer : _____ License/Permit # _____ Date: _____