Ministry of Health

Ontario

COVID-19 Vaccine Consent Form

CONSENT FORM -COVID-19 Vaccine

Version 3.0 – March XX, 2021

Last Name	First Name	Identification (e.g., health card number)
Gender: ☐ Female ☐ Male ☐ Prefer not to answer ☐ Other: ______________		Primary Care Clinician (Family Physician or Nurse Practitioner)
If Indigenous, please indicate which Indigenous identity: ☐ First Nations ☐ Métis (includes members of the Métis organization or Settlement) ☐ Inuk/ Inuit ☐ Other Indigenous, specify: ______________ ☐ Prefer not to answer ☐ Unknown		
Home Phone	Mobile Phone	

Street Address	City	Province	Postal Code

Date of Birth (month, day, year)	Age	Is this your **first or second dose** of the vaccine? ☐ First ☐Second
______ / _______ / _______		If second, please indicate the date of the first dose and name of vaccine administered: --------/----------/-------- (month, day, year) Name of vaccine administered: _________________________

Consent to Receive the Vaccine

I have read (or it has been read to me) and I understand the Immunization Prepackage, including the following documents: 'COVID-19 Vaccine Information Sheet' and 'What you need to know about your Covid-19 vaccine appointment'.

- I have had the opportunity to ask questions regarding the vaccine I am receiving and to have them answered to my satisfaction.

☐ **I consent to receiving the vaccine, including all recommended doses in the series.**

- I understand that I may withdraw this consent at any time.

- I understand that if I am withdrawing consent as a substitute decision maker of an individual, then I must contact the congregate setting that the individual resides in.

Note: Please contact the vaccination clinic where you are supposed to receive the Covid-19 vaccine if you change your mind and no longer consent to receiving the vaccine. This will allow someone else to take your spot. If consent has been withdrawn by a substitute decision maker of an individual who resides in a congregate setting, then the congregate setting must contact the local public health unit.

Acknowledgement of Collection, Use and Disclosure of Personal Health Information

The personal health information on this form is being collected for the purpose of providing care to you and creating an immunization record for you, and because it is necessary for the administration of Ontario's COVID-19 vaccination program. This information will be used and disclosed for these purposes, as well as other purposes authorized and required by law. For example,

- it will be disclosed to the Chief Medical Officer of Health and Ontario public health units where the disclosure is necessary for a purpose of the *Health Protection and Promotion Act*. And
- it may be disclosed, as part of your provincial electronic health record, to health care providers who are providing care to you.

The information will be stored in a health record system under the custody and control of the Ministry of Health.

Where a Clinic Site is administered by a hospital, the hospital will collect, use and disclose your information as an agent of the Ministry of Health.

☐ **I acknowledge that I have read and understand the above statement.**

You may be contacted by a hospital, local public health unit, or the Ministry of Health for purposes related to the COVID-19 vaccine (for example, to remind you of follow up appointments and to provide you with a record of immunization). If you consent to receiving these follow up communications by email, please indicate this using the box below.

☐ **I consent to receiving follow-up communications:**

☐ **by email** ☐ **by text/SMS**

If selected by email, please provide your email address: ____________________

Consent to Being Contacted About Research Studies

You have the option of consenting to be contacted by researchers about participation in COVID-19 vaccine related research studies. If you consent to be contacted, your personal health information will be used to determine which studies may be relevant to you, and your name and contact information will be disclosed to researchers. Consenting to be contacted about research studies does not mean you have consented to participate in the research itself. Participating in research is voluntary. You may refuse to consent to be contacted about research studies without impacting your eligibility to receive the COVID-19 vaccine.

If you do not wish to be contacted about research studies, please indicate this below.

If you consent to be contacted about research studies, and then change your mind, you may withdraw consent at any time by contacting the Ministry of Health at vaccine@ontario.ca.

This will not impact your eligibility to receive the Covid-19 vaccine.

I consent to be contacted about COVID-19 vaccine related research studies:

☐ by email ☐ by text/SMS ☐ by phone ☐ by mail

If selected by email, please provide your email address: ________________

☐ I do not consent to be contacted about COVID-19 related research studies:

Signature	Print Name	Date of Signature

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

☐ If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker.

Specific Issues re: Long-Term Care Homes Act, 2007

The resident's consent to receive the vaccine may be withdrawn or revoked at any time.

Statement respecting section 83 of the Act:

Please note the following legal protection:

Every licensee of a long-term care home shall ensure that no person is told or led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because,

(a) a document has not been signed;
(b) an agreement has been voided; or
(c) a consent or directive with respect to treatment or care has been given, not given, withdrawn or revoked.

FOR CLINIC USE ONLY								
Agent	COVID-19	Product Name		Lot #		Dose Amount:		
Anatomical Site	☐ Left deltoid ☐ Right deltoid			Route	Intramuscular (IM)	Dose #:		
Date Given	______ / ______ / ______ (m/d/yyyy)		Time Given	_____ : _____ am pm		AEFI? (after receiving current dose)	☐ Yes ☐ No	
Given By (Name, Designation)		Location		Authorized By				
Reason for Immunization	☐ Healthcare Worker ☐ LTC: Resident ☐ LTC: Healthcare Worker ☐ LTC: Other Non- Employee ☐ RH: Healthcare Worker ☐ RH: Resident ☐ RH: Essential Caregiver ☐ RH: Other Non-Employee ☐ Advanced Age: Community Dwelling ☐ Adult of Chronic Health Care							

	☐ Indigenous community ☐ Other Priority Population
Reason Immunization Not Given	☐ Immunization is contraindicated ☐ Practitioner recommends immunization but no PATIENT consent ☐ Practitioner decision to temporarily defer immunization ☐ Medically Ineligible ☐ Patient withdrew consent for series
Your dose 2 of 2 is scheduled for:	_____ / _____ / _____ (m/d/yyyy) ____ : ____ am pm