# VACCINE CONSENT FORM

Bonafide Compounding Pharmacy, 1598 Leger Way, Milton ON L9E 0B9
Phone: (905) 636-7880 Fax: (905) 875-9881

**PATIENT INFORMATION**

| | | | |
|---|---|---|---|
| ***First Name*** | ***Last Name*** | ***Gender*** | ***DOB*** |
| ***Weight*** | ***Address*** | | ***Phone Number*** |
| ***Emergency Contact*** | ***Relationship to Patient*** | ***Contacts Phone Number*** | |
| ***Ontario Health Card Number and Version Code*** | | ***Age as of today*** | |
| ***Email Address*** | | | |
| ***Brand*** *of Last COVID-19 Vaccine (if applicable)* | | ***Date*** *of Last COVID-19 Vaccine* | |

**SCREENING QUESTIONNAIRE** **Circle Your Answer**

| | | | |
|---|---|---|---|
| Have you had a COVID vaccine? If so, which one did you receive and when did you receive it? Detail: | YES | NO | UNSURE |
| Have you experienced major venous and/or arterial thrombosis with thrombocytopenia following vaccination with any vaccine? (This question is for patients receiving a viral vector based COVID vaccine.) | YES | NO | UNSURE |
| Have you experienced a previous cerebral venous sinus thrombosis (CVST) with thrombocytopenia or a heparin-induced thrombocytopenia (HIT)? (This question is for patients receiving a viral vector based COVID vaccine.) | YES | NO | UNSURE |
| Are you experiencing any cold, flu or COVID-19-like symptoms, even mild ones? Sore throat, cough, fever. Please inform the pharmacist if you are not feeling well | YES | NO | UNSURE |

| | | | |
|---|---|---|---|
| Have you travelled to any countries outside Canada (including the United States) within the last 14 days? | YES | NO | UNSURE |
| Did you provide care or have close contact with a person with confirmed COVID-19? | YES | NO | UNSURE |
| Have you received a flu vaccine or any other vaccine in the past 14 days? | YES | NO | UNSURE |
| Do you have a new or changing neurological disorder? | YES | NO | UNSURE |
| Have you ever had Guillain-Barre Syndrome within 6 weeks after receiving a vaccine? (A Yes answer is not a contraindication for mRNA based vaccines). | YES | NO | UNSURE |
| Are you or do you think you might be pregnant or breastfeeding? | YES | NO | UNSURE |
| Are you currently taking any medication? | YES | NO | UNSURE |
| Do you take a blood thinner or have a bleeding disorder? | YES | NO | UNSURE |
| Do you have an autoimmune disorder or weakened immunity due to illness/treatment? Eg. Taking high dose steroids, anticancer or transplant medications | YES | NO | UNSURE |
| Are you allergic to latex gloves? | YES | NO | UNSURE |
| Do you have a history of chronic illness or autoimmune condition? Ie. Rheumatoid arthritis, multiple sclerosis,Crohn's disease, Lupus) | YES | NO | UNSURE |
| Do you have any medical conditions that require regular visits to a primary care provider eg. doctor | | | |
| Do you have a history of fainting or feeling faint after a vaccine or medical procedure? | YES | NO | UNSURE |
| In the past 6 months, have you previously tested positive for a COVID-19 Infection? | YES | NO | UNSURE |
| Have you experienced serious side effects from a previous COVID-19 Vaccine? | YES | NO | UNSURE |
| Have you had a severe or anaphylactic reaction to another vaccine in the past?(ie Difficulty breathing, itchy/swelling of lips/tongue, hives | YES | NO | UNSURE |
| In the last 3 months have you previously been admitted to the hospital due to a COVID-19 infection and treated with convalescent plasma or monoclonal antibodies (received treatment IV) | YES | NO | UNSURE |
| Do you have a history of any of the following:<br>-Heparin- Induced thrombocytopenia (HIT)<br>-Thrombosis associated with lupus anticoagulant (thrombotic antiphospholipid syndrome)<br>-Capillary Leak Syndrome<br>-Cerebral Venous Sinus Thrombosis (CVST) or thrombocytopenia<br>-Multisystem inflammatory syndrome in children (MIS-C)<br>-Venous or arterial thrombosis with thrombocytopenia following a viral vector vaccine (eg. AstraZeneca COVISHIELD Vaccines)<br>-Myocarditis or pericarditis following the first dose of mRNA COVID-19 Vaccine (eg. Pfizer, Moderna) | YES | NO | UNSURE |

| | | | |
|---|---|---|---|
| Do you require a tuberculin skin testing (TST) or interferon gamma release assay (IGRA) test within the next 4 weeks? | YES | NO | UNSURE |
| Do you have a known or suspected allergy to any of the components of any vaccine eg. Tromethamine, polysorbate 80, polyethylene glycol ( PEG ) | YES | NO | UNSURE |

**CONSENT GIVEN BY PATIENT/GUARDIAN/AGENT**

I, the undersigned patient/guardian/agent, have read or had explained to me information about the all vaccines that will be administered today as outlined on the Fact Sheet. I have had a chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the vaccine(s). I agree to
wait/have my child wait/have the client wait in the pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the vaccine(s). I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called "anaphylaxis" can be life-threatening and is a medical emergency. If I/my child/my client experience such a reaction following vaccination, I am aware that it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 9-1-1 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. In the event of anaphylaxis, a copy of this form containing information on emergency treatments received will be provided to you, your guardian, your agent or EMS paramedics.
Common side effects of vaccines include: soreness, tenderness, redness and/or swelling in the injection site
Less frequent side effects include: mild fever, headache, and/or muscle aches
If you experience a high fever or unexpected prolonged side effects (more than 2 days) contact your doctor promptly.
Signing this consent form will confirm the informed consent of participation in a Vaccine appointment between myself and Bonafide Compounding Pharmacy.
I consent to the collection, use, disclosure and storage if my health information.
The information I have provided is accurate to the best of my knowledge
I have reviewed the information above and confirm that my answers are accurate. I understand that eligibility for the service will be confirmed by the Pharmacy team at the time of the appointment

□ I confirm that I want to receive the requested vaccine(s)

**OR**

□ I confirm that I have the legal authority to consent to this immunization (s)

| *Patient/Guardian/Agent Name* | *Patient/Guardian/Agent Signature* | *Relationship* | *Date Signed* |
|---|---|---|---|
| | | | |

**PHARMACIST DECLARATION** I confirm the above named patient/guardian/agent is capable of providing consent for vaccines and that the requested vaccine(s) should be given to the patient.

| *Pharmacist* | *Pharmacist Signature* | *Date Signed* |
|---|---|---|
| | | |

## Immunization Record

# PHARMACY USE ONLY

| *First Name* | *Last Name* | *Gender* | *Weight* | *DOB* |
|---|---|---|---|---|
| | | | | |
| *Address* | *Health Card #* | | *Phone #* | |
| | | | | |

| **Vaccination** | **Trade Name/Lot #/ Expiry** | **Dosage (Circle)** | **Dose # Check &Initial** | **Next Dose Schedule (# of months after 1st dose)** |
|---|---|---|---|---|
| □ **Hepatitis A** | Trade Name:<br>Lot #:<br>Expiry: | 1-18 yrs: 0.5mL<br><br>19+ yrs: 1.0mL | □ 1<br>□ 2 | Dose 2: 6 months<br><br>Date: |
| Date and Time of vaccination: | | Site: □ Left Arm □ Right Arm □IM | | |
| □ **Hepatitis B** | Trade Name:<br>Lot #:<br>Expiry: | 1-18 yrs: 0.5mL<br><br>19+ yrs: 1.0mL | □ 1<br>□ 2<br>□ 3 | Dose 2: 1 month<br>Dose 3: 6 month<br><br>Date: |
| Date and Time of vaccination: | | Site: □ Left Arm □ Right Arm □IM | | |
| □ **Hepatitis A & B** | Trade Name:<br>Lot #:<br>Expiry: | Twinrix Jr. 0.5 mL<br>Twinrix: 1.0 mL | □ 1<br>□ 2<br>□ 3 | Dose 2: 1 month<br>Dose 3: 6 month<br><br>Date: |
| Date and Time of vaccination: | | Site: □ Left Arm □ Right Arm □IM | | |
| □ **Pneumococcus** | Trade Name:<br>Lot #:<br>Expiry: | All ages:0.5mL | □ 1<br>□ 2 | Date |
| Date and Time of vaccination: | | Site: □ Left Arm □ Right Arm □IM □SC | | |
| □ **Human Papilloma Virus** | Trade Name:<br>Lot #:<br>Expiry: | 9-26 years:<br>0.5mL | □ 1<br>□ 2<br>□ 3 | Dose 2: 2 month<br>Dose 3: 6 month<br><br>Date: |
| Date and Time of vaccination: | | Site: □ Left Arm □ Right Arm □IM | | |
| □ **Herpes Zoster (Shingles)** | Trade Name:<br>Lot #:<br>Expiry: | 50 yrs + | □ 1<br>□ 2 | Primary Dose Only<br>Dose 2: 2-6 months<br><br>Date: |
| Date and Time of vaccination: | | Site: □ Left Arm □ Right Arm □IM □SC | | |
| □ **Influenza (Flu)** | Trade Name:<br>Lot #:<br>Expiry: | All Ages:<br>0.5mL | □ 1<br>□ 2 | Dose 2: 1 month (only if <9 yrs & previously unvaccinated) |
| Date and Time of vaccination: | | Site: □ Left Arm □Right Arm □IM □Nose | | |
| □ **Other:** | Trade Name:<br>Lot #:<br>Expiry: | | | |
| Date and Time of vaccination: | | Site: □ Left Arm □ Right Arm □IM □SC | | |

## COVID-19 VACCINE

| Product | DIN | DOSE |
|---|---|---|
| □ Comiraty Omicron XXB 1.5 10mcg/0.3mL (pack size 1.8mL) | **02541858** | 0.3mL |
| □ Comiraty Omicron XXB 1.5 30mcg/0.3mL (pack size 1.8mL) | **02541823** | 0.3mL |
| □ Comiraty Omicron XXB 1.5 3mcg/0.2mL (pack size 2mL) | **02541866** | 0.2mL |
| □ Novavax (Pack Size 5) | 02525364 | 0.5mL |
| □ Nuvaxovid 5mcg/0.5mL (Pack Size 5mL) | 02525364 | 0.5mL |
| □Moderna COVID-19 Vaccine 100mcg/0.5mL (Pack Size 5 ML) | **02510014** | |
| □ Other: | | |

| *Route of Administration* | *Site of Administration* | *Lot Number* | *Expiry Date* |
|---|---|---|---|
| | | | |

| *Administered by Name and OCP #* | *Administered By <Pharmacist>* | *Date/Time of Immunization* |
|---|---|---|
| | | |

**EPINEPHRINE EMERGENCY TREATMENT**

| Product | DIN | PIN | DOSE |
|---|---|---|---|
| □ Allerject 0.15mg/0.15ml (Pack Size 1 PEN) - ODB emergency use | **02382059** | **09857439** | **1 Pen** |
| □ Allerject 0.3mg/0.3ml (Pack Size 1 PEN) - ODB emergency use | **02382067** | **09857440** | **1 Pen** |
| □ Emerade 0.3mg/0.3mL (Pack Size 0.3 ML) - ODB emergency use | **02458446** | **09858129** | **1 Pen** |
| □ Emerade 0.5mg/0.5mL (Pack Size 0.5 ML) - ODB emergency use | **02458454** | **09858130** | **1 Pen** |
| □ Epipen 1mg/mL (Pack Size 1 PEN) - ODB emergency use | **00509558** | **09857423** | **1 Pen** |
| □ Epipen Jr 0.15mg/0.3mL (Pack Size 1 PEN) - ODB emergency use | **00578657** | **09857424** | **1 Pen** |

| *Route of Administration* | *Site of Administration* | *Lot Number* | *Expiry Date* |
|---|---|---|---|
| | | | |

| *Administered by Name and OCP #* | *Administered By <Pharmacist>* | *Date/Time of Immunization* |
|---|---|---|
| | | |

| Comments |
|---|