

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? Yes No If yes, what type: SHA SHA LTC non-SHA non-SHA LTC PCH <small>(SHA=Saskatchewan Health Authority; LTC= long-term care; PCH=personal care home)</small>		
Screening		
The following questions will help determine if a vaccine is right for you today. A “yes” to any question does not necessarily mean you should not be vaccinated, but your pharmacist may have some additional questions for you.		
1. Have you received any previous COVID-19 vaccine ?	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, itching/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 or 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) ?	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

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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 must be entered into the [Vaccine Risk Factor Portal](#) before entering the prescription and billing to DPEBB. Healthcare Worker type(s) (if applicable):

SHA SHA ITC non-SHA non-SHA ITC PCH
(SHA=Saskatchewan Health Authority; ITC= long-term care; PCH=personal care home)

Vaccine Details

Vaccine Name:	Age Appropriate?	Manufacturer:	DIN:	Lot #:	Expiry Date:
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Vaccine Preparation

Vaccine Drawn by (Name):	Date & Time Vaccine Drawn:
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Vaccine Administration

Dosage:	Site:	Route:	Dose #:	Vaccine Administered by (Name):	Date & Time of Injection:
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Adverse reaction: No Yes – describe reaction below

Completed Adverse Event Following Immunization (AEFI) form

(See <https://formulary.drugplan.ehealthsask.ca/COVIDImmunizationProgram>, Section 9 for form and reporting instructions.)

Vaccine Name	Manufacturer	DIN	Dosage
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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