Services de santé du TIMISKAMING Health Unit

SCHOOL IMMUNIZATION CONSENT COVID-19

1. STUDENT INFORMATION (please print)

Legal Last Name	Legal First Name			Male	Female	Other
Birthday Year	Month	Day	School		Class or Teacher's Name	
Parent / Legal Guardian Name		Relationship to Student	Home Phone:		Work or Cell:	

2. STUDENT IMMUNIZATION

My child has **already received** the following: *(circle trade name & provide dates vaccines were given)*

◯ COVID-19 vaccine
Pediatric Pfizer

dates: _____ yyyy/mm/dd _____ yyyy/mm/dd

3. STUDENT HEALTH HISTORY

			If "yes," explain
a)	Has your child ever had a reaction to a vaccine?	❍ Yes ❍ No	
b)	Does your child have a history of fainting?	❍ Yes ❍ No	
c)	Does your child have a serious medical condition?	❍ Yes ❍ No	
d)	Does your child have a weak immune system or taking a medication that increases the risk of infection? (e.g. corticosteroids)	❍ Yes ❍ No	
e)	Has your child had a serious allergic reaction or a reaction within 4 hours to the COVID-19 vaccine before?	❍ Yes ❍ No	If yes: Precaution. Needs evaluation by physician or NP
f)	Does your child have allergies to Tromethamine(found in contrast media, oral and injectable meds) polyethelene glycol or polysorbate (PEG is a common ingredient in medical products, prescription meds, over the counter and skin care products. Polysorbate is commonly found in medical preparations , cosmetics, foods such as chewing gum, ice cream, puddings, etc)?	❍ Yes ❍ No	If yes: Precaution. Needs evaluation by physician or NP
g)	Has your child received a vaccine in the last 14 days?	❍ Yes ❍ No	If yes: Covid-19 vaccine should be deferred-as a precaution but, with informed consent, can be given
h)	Does your child have a bleeding disorder or are they taking blood thinning medications?	❍ Yes ❍ No	If yes: Bleeding disorder conditions should be managed prior to immunization. COVID-19 vaccine should be offered.

4. CONSENT FOR VACCINATION

I have read the attached immunization vaccine fact sheet. I understand the expected benefits and possible risks and side effects of the vaccines. I understand the possible risks to my child if not vaccinated. I have had the opportunity to have my questions answered by the Timiskaming Health Unit. This consent is valid for two years. I understand that I can withdraw my consent at any time.

INDICATE YOUR CONSENT BY CIRCLING YES OR NO AND SIGN:

YES	I authorize the Timiskaming Health Unit to administer **two doses of** Pediatric **Pfizer vaccine** to my child to be given optimally with 8 weeks (56 days) between and minimally at least 21 days apart.
NO	I do not authorize the Timiskaming Health Unit to vaccinate my child with Pediatric Pfizer vaccine

X _____ _____

Signature of Parent ☐ **or Legal Guardian** ☐ **Date**

TIMISKAMING HEALTH UNIT USE ONLY (Checklist to assist with assessment. Use vaccine administration section only if unable to record in *COVax*)

1. **Use 2 client identifiers**
2. **Pfizer 2-dose schedule**: is there a minimum of 21 days since dose one?
3. Has student received Pediatric Pfizer vaccine from another health care provider?
4. Does student understand what the vaccine(s) are for?
5. Verify if they have ever had a reaction to a vaccine?
6. Inquire if student has any allergies.
7. Inquire if anything changed with students health recently.
8. Inquire if student has a fever today.

PFIZER VACCINE (COVID-19)

Dose 1	Dose 2
○ **Pediatric Pfizer 0.2 mL IM**	○ **Pediatric Pfizer 0.2mL IM**
DATE _____	**DATE** _____
TIME _____	**TIME** _____
LOT# _____	**LOT#** _____
DELTOID: Left Right	DELTOID: Left Right
SIGNATURE:	SIGNATURE:
COVax entered by:	COVax entered by:

The information provided or attached to this form is being collected, and will be used by, Timiskaming Health Unit (THU) for the purpose of the Medical Officer of Health maintaining an immunization record on the above named student and to take appropriate action to prevent certain vaccine preventable diseases. THU will enter your child's immunization information into a secure provincial immunization database called *COVax*. Your child's immunization information may be shared with or accessed by another health care provider for the purpose of providing care to you or your dependent, and otherwise as required or permitted by law. If you do not want this information shared please provide notification to the address provided. If you have questions about the privacy of your child's immunization information, please contact us at 43-247 Whitewood Avenue P.O Box 1090 New Liskeard, ON P0J 1P0.