

COVID-19 mRNA Vaccine Consent Form [Moderna]

CLINIC LOCATION: _____

1. CLIENT INFORMATION

Client's Last Name				Client's First Name			
Date of Birth	Year	Month	Day	Age	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Self-identify: _____
Health Card #				Email			
Address				Postal Code		Cell / Home Phone	

2. HEALTH ASSESSMENT

- a) Have you been sick recently? Do you have COVID-19 symptoms or a fever? YES NO
- b) Do you have any severe allergies? Have you ever had an anaphylactic reaction? YES NO
- c) Have you ever had a serious reaction to a vaccine before? To polyethylene glycol? YES NO
- d) Are you pregnant, breastfeeding or planning a pregnancy? YES NO
- e) Do you have an autoimmune disorder, or weakened immunity due to illness/treatment? YES NO
- f) Do you have any neurological disorder, bleeding disorder or taking a blood thinner? YES NO
- g) Do you have a history of fainting? YES NO
- h) Have you received a flu vaccine or any vaccine in the past 14 days? YES NO

Moderna vaccine Ingredients

- mRNA (medicinal ingredient)
- 1,2-distearoyl-sn-glycero-3-phosphocholine (DSPC)
- acetic acid, cholesterol, lipid SM-102
- PEG2000DMG1,2-dimyristoyl-rac-glycerol, methoxy-polyethyleneglycol
- tromethamine, tromethamine hydrochloride
- sodium acetate, sucrose & water for injection

3. CONSENT FOR VACCINATION

I have read the attached mRNA COVID-19 vaccine fact sheet. I understand the expected benefits and possible risks and side effects of the vaccines. I understand the possible risks to myself if I am not vaccinated. I have had the opportunity to have my questions answered by Toronto Public Health.

I authorize Toronto Public Health to administer the mRNA COVID-19 vaccine to myself.

X

Signature of Client

Date

4. SCREENING FOR CLIENTS WITH HEALTH CONDITIONS: N/A **YES, Client is Eligible for Vaccination**

- If it has been 3 months post-chemotherapy and the cancer is in remission
- If immunosuppression therapy has been discontinued for at least 3 months
- If immunosuppression therapy has been discontinued for at least 6 months for anti-B cell antibodies
- With stable hepatitis B or C, or living with HIV
- Using blood thinner medication

 Clients on anticoagulant therapy (blood thinner medication)

Use a small gauge needle and apply pressure to injection site for 3 to 5 minutes after vaccination to reduce bruising. There is no need to measure the blood thinning level (INR test) prior to vaccination. Continue INR testing according to the schedule recommended by the attending physician.

5. VACCINE ADMINISTRATION: Nurse to Complete

Moderna mRNA COVID-19 Vaccine: Two-dose series given 28 day interval (minimum 21 days)

Do not shake vial. Swirl the vial gently after thawing and between each withdrawal.

One dose = 0.5mL (100 mcg of mRNA)

Dose 1:	0.5mL <input type="checkbox"/>	Dose 2:	0.5mL <input type="checkbox"/>
IM Injection to deltoid	left <input type="checkbox"/> right <input type="checkbox"/>	IM Injection to deltoid	left <input type="checkbox"/> right <input type="checkbox"/>
Lot #	expiry date:	Lot #	expiry date:
loading nurse:		loading nurse:	
dosing nurse signature:		dosing nurse:	
dosing date & time:		dosing date & time:	

Notes:

Personal health information on this form is collected under the authority of the Health Protection and Promotion Act. It is used to administer the Toronto Public Health Vaccine Preventable Diseases Program. For more information, visit our Privacy Statement at tph.to/personalhealthinfo or contact, VPD Manager at 416-392-1250.