

**COVID-19 Vaccine Children/ Youth (Age 5-17) Consent Form**

Version 3.0 –November 22, 2021

Child/Youth Last Name:	Child/Youth First Name:	Child/Youth Identification number (e.g., health card number):	
Child/Youth Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____		Child/Youth's Primary Care Clinician (Family Physician, Pediatrician, or Nurse Practitioner):	
If Indigenous, please indicate Child/Youth's Indigenous identity: <input type="checkbox"/> First Nations <input type="checkbox"/> Métis (includes members of the Métis organization or Settlement) <input type="checkbox"/> Inuk/Inuit <input type="checkbox"/> Other Indigenous, specify: _____ <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Unknown			
Mobile Phone:	Parent/legal guardian phone:		
Street Address:	City:	Province:	Postal Code:
Child/Youth Date of Birth:  ____ / ____ / ____ month      day      year	School the Child/Youth is currently attending:  _____ <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Home school <input type="checkbox"/> Unknown <input type="checkbox"/> Not attending school		
Has the Child/Youth previously received one or more doses of a COVID-19 vaccine? If yes, please complete the information below for all doses of vaccine received.			
First Dose date: -----/-----/----- (month, day, year)			
First dose product name: _____			
Second Dose date: -----/-----/----- (month, day, year)			
Second dose product name: _____			

## 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' or the 'COVID-19 Vaccine Information Sheet: For Children (age 5-11)' and What you need to know about your Covid-19 vaccine appointment. I have had the opportunity to ask questions regarding the vaccine and to have them answered to my satisfaction. I understand that I may withdraw this consent at any time.

I consent to receiving all recommended doses in the vaccine series.

**OR**

I am consenting on the patient's behalf to receive all recommended doses in the vaccine series and I confirm that I am the patient's substitute decision maker (e.g., parent, legal guardian).

Note: Please contact the vaccination clinic if you no longer consent to receiving the vaccine. If consent has been withdrawn by a substitute decision maker of an individual who resides in a congregate setting, then the congregate setting must contact the local public health unit.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 in accordance with the *COVID 19, Vaccination Reporting Act, 2021* for the purpose of providing care and creating an immunization record, 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 in accordance with the *Personal Health Information Protection Act, 2004* and as 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, to provide you with a record of immunization). If you agree to receiving these follow up communications by email or text/SMS, please indicate this using the box below.

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

**by email**       **by text/SMS**

**If you agreed to be contacted by email or text/SMS, please provide your email address or your text/SMS number:** \_\_\_\_\_

### **Consent to Being Contacted About Research Studies**

You have the option of consenting to be contacted about participation in COVID-19 vaccine related research studies/surveys. If you consent to be contacted, personal health information may be used 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. You may refuse to be contacted about research studies without impacting eligibility to receive the COVID-19 vaccine. If you change your mind, you may withdraw consent at any time by contacting the Ministry of Health at [vaccine@ontario.ca](mailto:vaccine@ontario.ca).

**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 myself, I confirm that I am the substitute decision maker.

If signing for someone other than yourself, indicate your relationship to the person you are signing for: \_\_\_\_\_

**FOR CLINIC USE ONLY**

Agent	COVID-19	Product Name	Lot #	Dose Amount:
Anatomical Site	<input type="checkbox"/> Left deltoid <input type="checkbox"/> Right deltoid	Route	Intramuscular (IM)	Dose #:
Date Given	_____ / _____ / _____ (mm/dd/yyyy)	Time Given	_____ : _____ am pm	AEFI? (after receiving current dose) <input type="checkbox"/> Yes <input type="checkbox"/> No
Given By (Name, Designation)			Location	
Authorized By				
Reason for Immunization	<input type="checkbox"/> Child/Youth 5+ <input type="checkbox"/> Age Priority Population – Age Eligible Population <input type="checkbox"/> Other reason: _____			
Reason Immunization Not Given	<input type="checkbox"/> Immunization is contraindicated <input type="checkbox"/> Practitioner recommends immunization but no PATIENT consent <input type="checkbox"/> Practitioner decision to temporarily defer immunization <input type="checkbox"/> Medically Ineligible <input type="checkbox"/> Patient withdrew consent for series			
Your next dose is scheduled for:	_____ / _____ / _____ (mm/dd/yyyy) _____ : _____ am pm			