Ministry of Health

Ontario

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: ☐ Female ☐ Male
☐ Prefer not to answer ☐ Other: ______________

If Indigenous, please indicate Child/Youth's Indigenous identity:

☐ First Nations
☐ Métis (includes members of the Métis organization or Settlement)
☐ Inuk/Inuit
☐ Other Indigenous, specify: ____________________________
☐ Prefer not to answer
☐ Unknown

Child/Youth's Primary Care Clinician (Family Physician, Pediatrician, or Nurse Practitioner):

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:

____

☐ Prefer not to answer
☐ Home school
☐ Unknown
☐ 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 a 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 If consent has been withdrawn by a substitute decision maker of an individual who resides in a congregate setting, then the congregate setting must contact the local public health unit.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.

☐ **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: _________________________________

<table>
<tr><th colspan="10">FOR CLINIC USE ONLY</th></tr>
<tr><td>Agent</td><td>COVID-19</td><td>Product Name</td><td colspan="2"></td><td>Lot #</td><td></td><td>Dose Amount:</td><td colspan="2"></td></tr>
<tr><td>Anatomical Site</td><td colspan="2">☐ Left deltoid
☐ Right deltoid</td><td>Route</td><td colspan="3">Intramuscular (IM)</td><td>Dose #:</td><td colspan="2"></td></tr>
<tr><td>Date Given</td><td colspan="3">______ / ______ / ______
(mm/dd/yyyy)</td><td>Time Given</td><td>____ : ____
am
pm</td><td colspan="2">AEFI? (after receiving current dose)</td><td colspan="2">☐ Yes
☐ No</td></tr>
<tr><td>Given By (Name, Designation)</td><td colspan="4"></td><td>Location</td><td colspan="4"></td></tr>
<tr><td>Authorized By</td><td colspan="9"></td></tr>
<tr><td>Reason for Immunization</td><td colspan="9">☐ Child/Youth 5+
☐ Age Priority Population – Age Eligible Population
☐ Other reason: __________________________________</td></tr>
<tr><td>Reason Immunization Not Given</td><td colspan="9">☐ Immunization is contraindicated
☐ Practitioner recommends immunization but no PATIENT consent
☐ Practitioner decision to temporarily defer immunization
☐ Medically Ineligible
☐ Patient withdrew consent for series</td></tr>
<tr><td>Your next dose is scheduled for:</td><td colspan="9">______ / ______ / ______ (mm/dd/yyyy) ____ : ____ am pm</td></tr>
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