Ontario

COVID-19 Vaccine Consent and Notice Form

SECTION ONE: Patient information

By completing this form, I am indicating my desire to receive a COVID-19 vaccine and subsequent recommended doses for which I may be eligible. I acknowledge that I have had the opportunity to ask questions regarding the vaccine I am receiving and have had them answered to my satisfaction.

Last Name	First Name	Middle Name	Identification (e.g., Health Card Number)
Street Address	**City**	**Province**	**Postal Code**
Home Phone	**Mobile Phone**	**Email**	
Sex		**Age (years)**	**Date of Birth (DD/MM/YYYY)**
☐ Male ☐ Female ☐ Prefer not to answer			
Primary Care Clinician (Family Physician/Pediatrician or Nurse Practitioner)			

SECTION TWO: Notice of Collection, Use and Disclosure of Personal Health Information

The personal health information is being collected for the purpose of providing care to you and creating a clinical record for you, and because it supports the Government of Ontario's ability to plan for, and prevent the spread of, COVID-19. Your personal health information, as described in the *COVID-19 Vaccination Reporting Act,* will be stored in a health record system under the custody and control of the Ministry of Health. This information will be used and disclosed for these purposes, as well as other purposes 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*.

- It may be disclosed, as part of your provincial electronic health record, to health care providers who are providing care to you.

I understand that I may restrict the disclosure of my personal health information for treatment purposes at any time by emailing vaccine@ontario.ca.

SECTION THREE: Consent for Communication and Research

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 and to provide you with a record of immunization). If you consent to receiving these follow up communications by email, please indicate this using the box below.

☐ I consent to receiving follow-up communications:

☐ by SMS/text: _____ ☐ by email: _____

You also have the option of consenting to be contacted about participation in COVID-19 related research studies/surveys. If you consent to be contacted, personal health information may be used to determine which studies may be relevant to you 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. Participating in research is voluntary. You may refuse to consent to be contacted about research studies without impacting your eligibility to receive the COVID-19 vaccine.

☐ I consent to be contacted about COVID-19 related research studies after receiving a COVID-19 vaccine:

☐ by SMS/text: _____ ☐ by Phone: _____

☐ by email: _____

☐ by mail:

_____

I understand that I may withdraw this consent to be contacted for follow-up communications or research studies at any time by emailing vaccine@ontario.ca.

Printed Name	Signature	Date of Signature (DD/MM/YYYY)

If signing for someone other than yourself, indicate your relationship to that other person:

_____

☐ If signing for someone other than myself, I confirm that I have the legal authority to provide consent for the individual that is to receive the COVID-19 vaccine (i.e. you are a parent, legal guardian, or substitute decision maker)

FOR CLINIC USE ONLY			
Agent	Product Name	Lot #	
COVID-19			
Anatomical Site		Route	Dosage:
☐ Left deltoid ☐ Right deltoid		Intramuscular	
Date Given (DD/MM/YYYY)		Time Given	AEFI (After receiving current dose)
			☐ Yes ☐ No