COVID-19 Immunization Enhanced Consent Form

Manitoba

Region ____________ Clinic Location ____________ Date ____________

Sections A, B and C completed by:

☐ Client ☐ Parent ☐ Legal decision maker ☐ Other ____________ (on behalf of client)

A. Client Information – please print

Surname ____________ Given Names ____________

Address of residence ____________ City/Town ____________ Postal Code ____________

Phone Number ____________ Date of Birth (yyyy/mm/dd) ______/______/______

Sex ☐ Male ☐ Female ☐ Intersex ☐ Unknown

Manitoba Health Number (6 digits) ____________ Personal Health Information Number (9 digits) ____________

B. Enhanced Health History of Client

If your immune system is suppressed due to disease or treatment, complete questions 1 thru 5.

1. I have read and understood the information in the COVID-19 Vaccine factsheet AND the information provided to me by my immunizer or health care provider. ☐Yes ☐No
2. I understand that there is limited evidence that immunosuppression is an independent risk factor for severe COVID-19. ☐Yes ☐No
3. I understand that immunocompromising conditions vary in their impact on the immune system and may alter the response to immunization depending on the underlying condition, the progression of disease and use of medications that suppress immune function. ☐Yes ☐No
4. I understand that there is very limited data on the use of COVID-19 vaccine in individuals who are immunosuppressed. ☐Yes ☐No
5. I understand that there is limited evidence to demonstrate that the COVID-19 vaccine will be of benefit to me. ☐Yes ☐No

If you have an autoimmune condition, complete questions 6 thru 12.

6. I have read and understood the information in the COVID-19 Vaccine factsheet AND the information provided to me by my immunizer or health care provider. ☐Yes ☐No
7. I understand that there is limited evidence that having an autoimmune condition is an independent risk factor for severe COVID-19. ☐Yes ☐No
8. I understand that autoimmune conditions vary in their impact on the immune system and may alter the response to immunization depending on the underlying condition, the severity and progression of disease and use of medications that impact immune function. ☐Yes ☐No
9. I understand that there is very limited data on COVID-19 vaccination in individuals who have an autoimmune condition. ☐Yes ☐No
10. I understand that there is limited evidence to demonstrate that the COVID-19 vaccine will be of benefit to me. ☐Yes ☐No
11. I understand that it is possible that the COVID-19 vaccine could make my autoimmune condition worse although there is limited information to this effect. ☐Yes ☐No
12. I understand that fever is a possible side effect of vaccination which could make symptoms of my autoimmune condition **temporarily** worse. ☐Yes ☐No

If you are pregnant, planning to become pregnant or breastfeeding, complete questions 13 thru 19.

13. I have read and understood the information in the COVID-19 Vaccine factsheet AND the information provided to me by my immunizer or health care provider. ☐Yes ☐No
14. I understand that there is limited evidence that pregnancy is an independent risk factor for severe COVID-19. ☐Yes ☐No
15. I also understand that age (≥ 35 years old), asthma, obesity, pre-existing diabetes, pre-existing hypertension and heart disease are independent risk factors for severe COVID-19. ☐Yes ☐No
16. I understand that there is very limited data on the use of COVID-19 vaccine in pregnant and/or breastfeeding women. ☐Yes ☐No
17. I understand that there is no evidence to determine whether the COVID-19 vaccine poses a risk to the fetus and/or breastfed baby. ☐Yes ☐No
18. I understand that there is no data on whether the COVID-19 vaccine can be found in human milk. ☐Yes ☐No
19. I understand that there is no evidence to guide the time interval between the completion of the COVID-19 vaccine series and conception. The National Advisory Committee on Immunization (NACI) recommends delaying pregnancy by 28 days or more after the administration of the complete COVID-19 vaccine series. ☐Yes ☐No

C. Informed Consent

Immunizer or Health Care Provider
Surname and Given Names (please print) ____________

Immunizer or Health Care Provider Signature ____________ Date ____________

Client Signature ____________ Date ____________