BetterLife Home Medical

Covid 19 Immunization and Consent

14250 85Ave NW. Edmonton. Ab. Phone: 780-848-1717

Patient Name: _____ On file with Pharmacy: ☐ Yes ☐ No

Date of Birth (dd-mm-yyyy) :_____ Additional Info: Ht_____, Wt_____

PHN/AHC: _____Gender (Optional): _____ Healthcare Provider (Y / N)

Health Information for person being immunized:

Are you currently experiencing any symptoms that could be Covid-19 related (Fever,Chills,Sore Throat) ☐ No ☐ Yes

Have you travelled outside of Canada (or Authorized Zone) within the past 14 days ☐ No ☐ Yes

Does this person have any allergies, including allergies to any vaccine, medicine or food? ☐ No ☐ Yes

If yes, describe all:

Does this person have any chronic illness? ☐ No ☐ Yes Current Smoker? ☐ No ☐ Yes

If yes, describe all:

Is this person taking any medication? (Profile printed from Netcare ☐ Yes) ☐ No ☐ Yes

If yes, describe all:

Is this person pregnant? ☐ No ☐ Yes Is this Person Breastfeeding? ☐ No ☐ Yes

Has this person had Covid-19 Before? ☐ No ☐ Yes

Has this person been screened for Covid-19 previously? ☐ No ☐ Yes

If so, When? (dd-mmm-yyyy)

Has this person had another vaccine in the 14 days prior to, or planned within 28 days from any Covid 19 Vaccine ☐ No ☐ Yes

If yes, list:

Has this person had a Covid-19 Vaccine Previously? (If yes, When)_____ ☐ No ☐ Yes

Has this person ever had a side effect from a covid-19 vaccine ☐ No ☐ Yes

If yes, list:

Consent for Vaccination:

I confirm that I have read the Covid-19 Vaccine information. I know about, and understand the risks, benefits, and common side effects of this vaccine. Any questions I may have had about this person getting this vaccine have been answered by calling the local public health office or Health Link at 811.

I understand the information I have been given

I understand this consent is for **ALL** doses of the vaccine

I will contact the local public health office or healthcare provider giving the Covid-19 Vaccine if the person being immunized

- Has any changes to their health before getting any dose of the Covid-19 Vaccine
- Gets another vaccine in the 14 days before they receive the Covid-19 Vaccine
- Has a severe or unusual side effect after the first dose of the Covid-19 Vaccine (other than the expected side effect listed on the Covid-19 Vaccine sheet provided)

I consent to this person receiving the Covid-19 immunization

I understand that I may withdraw this consent at any time by notifying the healthcare provider administering the Covid-19 Vaccine

I confirm that I have the legal authority to consent to this immunization, and any additional care & follow up services indicated

Printed name of person providing consent	**Telephone Number**
Relationship to person being immunized (Select One) **☐ Parent (With legal authority) ☐ Agent** **☐ Guardian/Legal representative ☐ Co-decision maker**	**☐ Person being immunized**
Signature of person providing consent	**Date (dd-mmm-yyyy)**
Name of healthcare provider obtaining consent	**Signature of healthcare provider**

For Pharmacy Use
Documentation of Service/Rx