

Consent for COVID-19 Immunization

Glengarry Pharmacy
 #115, 12222 - 137 Avenue NW
 Edmonton, AB T4X 4X5
 780-473-6636
 drugs@glengarrypharmacy.com

- Please complete this form to the best of your knowledge prior to your scheduled COVID-19 vaccination appointment.
- Use this form if a parent or alternate decision-maker is not able to be with the person being immunized. An alternate decision-maker could be an agent, guardian, specific decision-maker or co-decision-maker. The parent or alternate decision-maker should **complete this form** and **send it** with the person being immunized. For alternate decision-makers – please also send a copy of documents to show that you are authorized to be the alternate decision-maker.

Personal information for the person being immunized		
Name (<i>Last, First, Middle</i>)	Date of Birth (<i>dd-mm-yyyy</i>)	
Alberta Healthcare Number (AHN)	Gender	
Health information for the person being immunized (<i>If you need more space, use the other side of this form.</i>)		
Does this person have any allergies, including allergies to any vaccine, medicine, or food? <input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, describe _____		
Does this person have any chronic illness? (<i>List all if more than one</i>) <input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, describe _____		
Is this person taking any medicine? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe _____		
Is this person pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes		Is this person breastfeeding? <input type="checkbox"/> No <input type="checkbox"/> Yes
Has this person had COVID-19 vaccine before? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when and what brand: _____		
Has this person ever had a side effect from COVID-19 immunization? <input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, describe _____		
Will this person get another vaccine in the 14 days before they get the COVID-19 vaccine? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Consent		
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 the pharmacist or calling 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 pharmacist giving the COVID-19 vaccine or Glengarry Pharmacy if this person: <ul style="list-style-type: none"> • has any changes to their health before getting any dose of the COVID-19 vaccine • gets another vaccine in the 14 days before they get any dose of 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 effects listed on the COVID-19 vaccine information sheet) 		
I consent to this person getting the COVID-19 immunization.		
I understand that I may withdraw this consent at any time by calling our pharmacy		
I confirm that I have the legal authority to consent to this immunization.		
Printed name of person giving consent	Daytime phone	Emergency Contact and Number
Relationship to person (if not yourself)		
<input type="checkbox"/> Parent (with legal authority to consent) <input type="checkbox"/> Co-decision-maker <input type="checkbox"/> Guardian/Legal representative <input type="checkbox"/> Specific decision-maker <input type="checkbox"/> Agent		
Signature of person giving consent		Date (dd-mm-yyyy)

