DISPENSARXIES

Consent for Administration of COVID-19 Vaccine

Pharmacy Label	

Please answer the following questions:	**Please**	
Do you have any allergies to food, medications, or vaccines?	YES	NO
Do you have any medical conditions?	YES	NO
Do you take any prescription medication or medications over the counter?	YES	NO
Have you ever had a serious reaction to a vaccine?	YES	NO
Female patients:		
Are you pregnant or planning to get pregnant within the next month?	YES	NO
Are you breastfeeding?	YES	NO
Please answer the following questions for vaccine second doses:	**Please**	
Have you ever had a side effect from COVID-19 immunization?	YES	NO
When was the date of your first dose?	DD/MM/YYYY	
Which vaccine did you receive for your first dose?		

- ☐ I understand that I may, at any time before, during, or after the injection, ask the pharmacist further questions.
- ☐ I have been provided information by the pharmacist around both the drug being administered and the injection procedure, and I understand the expected outcome/reaction as well as possible side effects.
- ☐ I understand that in order to receive the manufacturers stated efficacy of the COVID-19 vaccine, I may require the administration of a second dose of COVID-19 vaccine.
- ☐ I understand and agree to remain at the pharmacy for 15-30 minutes after injection as directed by the pharmacist.
- ☐ In the event of an emergency, I authorize the pharmacist to administer epinephrine and/or apply necessary life-saving procedures as an interim measure until medical support personnel arrive. In the case of an emergency, the pharmacist should contact_____ at_____(phone).
- ☐ I understand that I may experience symptoms following COVID-19 immunization (i.e., fever, cough, etc.) that are similar to symptoms that present with COVID-19 infection. I may refer to the care after immunization information sheet provided on actions to take if symptoms arise.

Signature of person giving consent: _____DATE:_____

Signature of parent/guardian giving consent: _____DATE:_____

OR

Signature of pharmacist: _____. DATE: _____

(TO BE USED BY A PHARMACIST IF CONSENT FOR ADMINISTRATION WAS PROVIDED VERBALLY BY A PATIENT TO A PHARMACIST)

Adapted from Alberta Health Service Consent for COVID-19 Immunization https://www.albertahealthservices.ca/frm-21765.pdf