



COVID-19 Pandemic
COVID-19 Vaccine Consent

INITIAL APPLICABLE BOXES

This form is to be used only for persons 18 years and older who are unable to understand or sign for their own medical services and have a legal substitute decision-maker.

Section 1: Client Information OR see addressograph/label above

Last Name	First Name	Gender M F
Health Services Number	Birthdate (MM/DD/YY)	Long Term Care or Personal Care Home (if applicable)

Section 2: Vaccine Screening Questions: (Substitute Decision-Maker or Physician to complete)

[COVID-19 Screening Questions](#) completed with substitute decision-maker or physician
Refer to saskatchewan.ca/COVID19 for more information.

- Does this person have severe allergies? No Yes – describe: _____
- Has this person reacted to previous vaccines? No Yes – describe: _____
- Is this person immune compromised or have an autoimmune condition? No Yes _____
- Is this person on any medication? No Yes – list _____
- Has this person received previous vaccines in the last 14 days? No Yes _____
- Does this person have any bleeding disorders? No Yes – describe: _____

Section 3: Consent for Vaccine (Substitute Decision-Maker to complete)

I have read the [COVID-19 information sheet\(s\)](#). I am aware that the Saskatchewan Health Authority may access immunization records from the provincial electronic immunization registry (Panorama) to determine the need for immunization. I am aware that immunizations and health related information will be documented in Panorama and may be shared with health care professionals to provide public health services, assist with diagnosis and treatment, and to control the spread of vaccine preventable diseases.

Name of Substitute Decision-Maker

Relationship to Client

Daytime Phone Number

I consent for the person named above to receive the COVID-19 Vaccine: Telephone Consent – see Section 4

Signature:

Date (MM/DD/YY):

Section 4: Telephone Consent (Health Care Provider to complete, if applicable)

Health Care Provider to obtain consent per Chapter 3 of the Saskatchewan Immunization Manual (SIM), including as it relates to Panorama under Section 3 above. **Complete section 3 first – signature below of person obtaining and telephone consent from substitute decision maker identified in section 3.**

Name of Health Care Provider (Print)

Health Care Provider Signature

Date (MM/DD/YY)