WINDSOR-ESSEX COUNTY HEALTH unit
Bureau de santé de Windsor-comté d'Essex

519-258-2146 | www.wechu.org

Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

COVID-19 mRNA Vaccine Consent Form [Moderna]

Facility Name: _____

Facility Location (site address):_____

CLIENT INFORMATION

Client's Last Name				Client's First Name	
Date of Birth Year	Month	Day	Age	Male ☐ Female ☐ Self-identify: _____	
Health Card #				Email	
Address				Postal Code	Cell / Home Phone

HEALTH ASSESSMENT

a)	Have you been sick recently? Do you have COVID-19 symptoms or a fever?	◯ YES ◯ NO
b)	Do you have any severe allergies? Have you ever had an anaphylactic reaction?	◯ YES ◯ NO
c)	Have you ever had a serious reaction to a vaccine before? To polyethylene glycol?	◯ YES ◯ NO
d)	Are you pregnant, breastfeeding or planning a pregnancy?	◯ YES ◯ NO
e)	Do you have an autoimmune disorder, or weakened immunity due to illness/treatment?	◯ YES ◯ NO
f)	Do you have any neurological disorder, bleeding disorder or taking a blood thinner?	◯ YES ◯ NO
g)	Do you have a history of fainting?	◯ YES ◯ NO
h)	Have you received a flu vaccine or any vaccine in the past 14 days?	◯ YES ◯ NO

Moderna vaccine Ingredients

- mRNA (medicinal ingredient)
- 1,2-distearoyl-sn-glycero-3-phosphocholine (DSPC)
- acetic acid, cholesterol, lipid SM-102
- PEG2000DMG1,2-dimyristoyl-rac-glycerol,methoxy-polyethyleneglycol
- tromethamine, tromethamine hydrochloride
- sodium acetate, sucrose & water for injection

CONSENT FOR VACCINATION

I have read the attached mRNA COVID-19 vaccine fact sheet. I understand the expected benefits and possible risks and side effects of the vaccine. I understand the possible risks to myself if I am not vaccinated. I have had the opportunity to have my questions answered by facility support staff or the Windsor-Essex County Health Unit.

I authorize the administration of the mRNA COVID-19 vaccine (Moderna).

X_____ _____

Signature of Client **Date**

X_____ _____

Signature of Decision Maker if applicable **Date**

SREENING FOR CLIENTS WITH HEALTH CONDITIONS

☐ **YES, Client is Eligible for Vaccination**

- If it has been 3 months post-chemotherapy and the cancer is in remission
- If immunosuppression therapy has been discontinued for at least 3 months
- If immunosuppression therapy has been discontinued for at least 6 months for anti-B cell antibodies
- With stable hepatitis B or C, or living with HIV
- Using blood thinner medication

☐ **Clients on anticoagulant therapy** (blood thinner medication)

Use a small gauge needle and apply pressure to injection site for 3 to 5 minutes after vaccination to reduce bruising. There is no need to measure the blood thinning level (INR test) prior to vaccination. Continue INR testing according to the schedule recommended by the attending physician.

VACCINE ADMINISTRATION: Nurse to Complete

Moderna mRNA COVID-19 Vaccine: Two-dose series given 28 day interval (minimum 21 days)	
Do not shake vial. Swirl the vial gently after thawing and between each withdrawal.	
One dose = 0.5mL (100 mcg of mRNA)	
Dose 1: **0.5mL** ☐	**Dose 2:** **0.5mL** ☐
IM Injection to deltoid left ☐ right ☐	IM Injection to deltoid left ☐ right ☐
Lot # expiry date:	Lot # expiry date:
loading nurse:	loading nurse:
dosing nurse signature:	dosing nurse:
dosing date & time:	dosing date & time:

Notes:

Personal health information on this form is collected under the authority of the Health Protection and Promotion Act. It is used to administer the Windsor-Essex County Health Unit Immunization Program. For more information, visit our Privacy Statement at https://www.wechu.org/key-policies/privacy-statement.