GLOBAL DRUGS IDA ALBERTA COVID-19 PHARMACY IMMUNIZATION PROGRAM CONSENT & SCREENING FORM

Name (Last, First,N	ion the person bein	ng immunize	ed					
Traine (Last, Flist,IV	liddle)		Date of Bir	th (dd-mm-y	/)			
Personal Health Nu	ımber (DHNI)		Emergency	Contact Na	me & Phone #			
1 Craonar realth we	imber (i riiv)		Lineigene	Contact Na	inc a r none #			
Health Information	n for the person being i	immunized						
Are you sick today?	? (i.e. fever greater thar	n 39.5°C, br	eathing problem	s, or active i	nfection)	□ Yes	□ No	
Do you have any al	llergies, including allergibe.	gies to latex	, any vaccine, m	edicine, or fo	od?	□ Yes	□ No	
Have you had a ser	rious reaction to, or fair	nted after re	ceiving any vacc	ine (includin	g COVID) in the past?	□ Yes	□ No)
Do you have any chronic illness or take any medications?						□ Yes	□ No)
Are you pregnant o	r breastfeeding?					□ Yes		No.
Have you had lymp	h nodes removed from	your arms	or chest or had a	a mastectom	y?	□ Yes	□ No	0
Have you received a vaccination in the last 14 days?						□ Yes	□ No)
Has you had COVID-19 vaccine before and/or had a reaction to COVID-19 vaccine?					e?	□ Yes	□ No)
Do you take blood t	thinning medications or	r do you hav	e a bleeding dis	order?		□ Yes	□ No	0
Consent for Immur	nization							
effects of this vacci local public health of	ne. Any questions I ma office or Health Link at	ay have had 811.			derstand the risks, benes vaccine have been an			
	nformation I have been	•						
I understand this of	consent is for all doses	of the vacci	ne.					
• has a sevexpected	ther vaccine in the 14 overe or unusual side ef I side effects listed on t	fect after the	e first dose of the	COVID-19	vaccine (other than the			
<u> </u>	erson getting the COVII	D-19 immur	19 vaccine inforr nization.	nation sheet	provided)		vacci	ne
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