



DT9593

**CONSENT FOR VACCINATION
AGAINST COVID-19
FOR USERS UNDER THE AGE OF 14**

User's last and first name					
Mother's last and first name					
Father's last and first name (optional)					
Date of birth		Year	Month	Day	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Health insurance number (if available)			Year	Month	Expiry date
Address (number, street)					
City				Postal code	

GENERAL INFORMATION					
Name of school:				Class:	
Authorized person to consent to vaccination (last name, first name):				Status: <input type="checkbox"/> Parental authority <input type="checkbox"/> Guardian	
Area code	Home phone no.	Area code	Other phone no.	<input type="checkbox"/> Cell	<input type="checkbox"/> Work
Email address:					

USERS UNDER AGE 14 (Written consent is not required for children age 14 and up, as they can provide their own consent for vaccination.)					
PRE-IMMUNIZATION QUESTIONNAIRE					
	QUESTIONS REGARDING YOUR CHILD'S HEALTH	YES	NO	N/A or IDK	DETAILS
1.	Health problems Do either of these situations apply to them: <ul style="list-style-type: none"> • They have had a positif test for COVID-19. • They have symptoms of COVID-19. • You have noticed a recent change in their condition (e.g., appearance of unusual symptoms). • They have a health condition that requires medical monitoring or regular medication. If either of these situations apply, please indicate details.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Immunosuppression Do either of these situations apply to them: <ul style="list-style-type: none"> • They take immunosuppressant drugs. • They have a disease that weakens the immune system, like cancer. If either of these situations apply, please indicate the drug or disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Previous reactions Have they ever had a significant reaction (other than a food, seasonal, or pet allergy) after receiving a vaccine or other product that required a visit at the hospital? If yes, please tell us what product caused this reaction.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Bleeding disorder Do they have or have they had a blood clotting disorder (e.g., thrombosis, thrombocytopenia) requiring medical attention or are they taking an anticoagulant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Immunization or blood products Do either of these situations apply to them: <ul style="list-style-type: none"> • They have received a vaccine in the last 14 days. • They have been hospitalized for COVID-19 treatment in the last 90 days. If either of these situations apply, please indicate the treatment or vaccine.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Legend:
 N/A : Not applicable
 IDK: I don't know

User's last and first name	Record no.
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PARENT/GUARDIAN CONSENT (DECISION)

As the parent or guardian of a child under the age of 14, you are in charge of vaccination decisions for this child.

Explanations to help you make an informed decision are provided in the leaflet attached to this form.

Your consent applies to 2 doses of COVID-19 messenger RNA vaccine (Pfizer).

If your child has already had positive test to COVID-19, the vaccinator will assess them and then administer the required number of doses; only one dose may be required.

Indicate whether or not your child may be vaccinated against COVID-19 with Pfizer RNA COVID-19 vaccine.

You may change your consent at any time.

- I CONSENT to have my child vaccinated against COVID-19.
- I DECLINE to have my child vaccinated against COVID-19.
- DOES NOT APPLY because my child has already been vaccinated against COVID-19.

Parent's or guardian's signature:		Date	Year	Month	Day