## NL COVID-19 PHARMACY IMMUNIZATION PROGRAM CONSENT & SCREENING FORM

Personal Informati	<b>on</b> for the person bein	g immunize	a					
Name (Last, First,M	iddle)		Date of Bir	th (dd-mm-y	y)	Weight:		
Personal Health Nu	mber (PHN)		Emergency	/ Contact Na	ame & Phone #			
Health Information	for the person being in	mmunized						
Are you sick today?	(i.e. fever greater than	n 39.5ºC, bre	eathing problem	s, or active i	nfection)	□ Yes	□ No	
Do you have any all If yes, please descri	ergies, including allerg	ies to latex,	any vaccine, m	edicine, or fo	ood?	□ Yes	s □ No	ı
Have you had a seri	ious reaction to, or fair	ited after red	ceiving any vaco	ine (includir	ng COVID) in the	past? □ Ye	s 🗆 No	)
Do you have any ch	ronic illness or take an	y medicatio	ns?			□ Ye	s 🗆 No	)
Are you pregnant or	breastfeeding?					□ Ye	s 🗆 N	0
Have you had lympl	n nodes removed from	your arms o	or chest or had a	a mastector	ıy?	□ Ye	s □N	0
Have you received a	a vaccination in the las	t 14 days?				□ Ye	s □ N	0
Have you had COV	ID-19 vaccine before a	nd/or had a	reaction to CO\	/ID-19 vacci	ne?	□ Ye	s 🗆 N	0
Do you take blood the	hinning medications, o	r do you hav	ve a bleeding dis	sorder?		□ Ye	s 🗆 N	0
Consent for Immun	ization							
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