

Region _____ Clinic Location _____ Date _____

Sections A, B and C completed by:

Client Parent Legal decision maker Other _____ (on behalf of client)

A. Client Information – please print

Surname _____ Given Names _____

Address of residence _____ City/Town _____ Postal Code _____

Phone Number _____ Date of Birth (yyyy/mm/dd) _____ / _____ / _____

Sex Male Female Intersex Unknown

Manitoba Health Number (6 digits) _____ Personal Health Information Number (9 digits) _____

B. Enhanced Health History of Client

If your immune system is suppressed due to disease or treatment, complete questions 1 thru 5.

1. I have read and understood the information in the COVID-19 Vaccine factsheet AND the information provided to me by my immunizer or health care provider. Yes No
2. I understand that there is limited evidence that immunosuppression is an independent risk factor for severe COVID-19. Yes No
3. I understand that immunocompromising conditions vary in their impact on the immune system and may alter the response to immunization depending on the underlying condition, the progression of disease and use of medications that suppress immune function. Yes No
4. I understand that there is very limited data on the use of COVID-19 vaccine in individuals who are immunosuppressed. Yes No
5. I understand that there is limited evidence to demonstrate that the COVID-19 vaccine will be of benefit to me. Yes No

If you have an autoimmune condition, complete questions 6 thru 12.

6. I have read and understood the information in the COVID-19 Vaccine factsheet AND the information provided to me by my immunizer or health care provider. Yes No
7. I understand that there is limited evidence that having an autoimmune condition is an independent risk factor for severe COVID-19. Yes No
8. I understand that autoimmune conditions vary in their impact on the immune system and may alter the response to immunization depending on the underlying condition, the severity and progression of disease and use of medications that impact immune function. Yes No
9. I understand that there is very limited data on COVID-19 vaccination in individuals who have an autoimmune condition. Yes No
10. I understand that there is limited evidence to demonstrate that the COVID-19 vaccine will be of benefit to me. Yes No
11. I understand that it is possible that the COVID-19 vaccine could make my autoimmune condition worse although there is limited information to this effect. Yes No
12. I understand that fever is a possible side effect of vaccination which could make symptoms of my autoimmune condition **temporarily** worse. Yes No

If you are pregnant, planning to become pregnant or breastfeeding, complete questions 13 thru 19.

13. I have read and understood the information in the COVID-19 Vaccine factsheet AND the information provided to me by my immunizer or health care provider. Yes No
14. I understand that there is limited evidence that pregnancy is an independent risk factor for severe COVID-19. Yes No
15. I also understand that age (≥ 35 years old), asthma, obesity, pre-existing diabetes, pre-existing hypertension and heart disease are independent risk factors for severe COVID-19. Yes No
16. I understand that there is very limited data on the use of COVID-19 vaccine in pregnant and/or breastfeeding women. Yes No
17. I understand that there is no evidence to determine whether the COVID-19 vaccine poses a risk to the fetus and/or breastfed baby. Yes No
18. I understand that there is no data on whether the COVID-19 vaccine can be found in human milk. Yes No
19. I understand that there is no evidence to guide the time interval between the completion of the COVID-19 vaccine series and conception. The National Advisory Committee on Immunization (NACI) recommends delaying pregnancy by 28 days or more after the administration of the complete COVID-19 vaccine series. Yes No
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C. Informed Consent

Immunizer or Health Care Provider

Surname and Given Names (please print) _____

Immunizer or Health Care Provider Signature _____ Date _____

Client Signature _____ Date _____