Santé
et Services sociaux
Québec

User's last and first name

Mother's last and first name

Father's last and first name (optionnal)

	Year	Month	Day	Sex
Date of birth				☐ M ☐ F

Health insurance number (if available)	Expiry date	Year	Month

Address (number, street)

City	Postal code

CONSENTEMENT FOR VACCINATION AGAINST COVID-19 FOR USERS UNDER AGE OF 14 AND INCAPACITATED USERS

GENERAL INFORMATION

Name of school:	Class:
Authorized person to consent to vaccination (last name, first name):	Status: ☐ Parental authority ☐ Legal representative
Area code Home phone no.	Area code Other phone no. ☐ Cell ☐ Work
Email address:	

USERS UNDER AGE 14 AND INCAPACITATED USERS

(Written consent is not required for users aged 14 and up, as they can provide their own consent for vaccination.)

PRE-IMMUNIZATION QUESTIONNAIRE

	QUESTIONS REGARDING THE USER'S HEALTH	YES	NO	N/A or IDK	DETAILS
1.	**Health problems** Do either of these situations apply to them: • They have had a positive 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.	☐	☐	☐	
2.	**Immunosuppression** Do either of these situations apply to them: • 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.	☐	☐	☐	
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.	☐	☐	☐	
4.	**Pregnancy** If the patient is a woman, is she pregnant?	☐	☐	☐	
5.	**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?	☐	☐	☐	
6.	**Immunization or blood products** They have been hospitalized for COVID-19 treatment in the last 90 days. If this situation apply, please indicate the treatment or vaccine.	☐	☐	☐	

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

User's last and first name	Record no.

CONSENT (DECISION) OF PARENT OR LEGAL REPRESENTATIVE

As the parent or legal representative of a user under the age of 14 or an incapacitated user, you are in charge of vaccination decisions for this individual.

The information in the sheet intended for the population targeted by the Protocole d'immunisation du Québec (PIQ) has been communicated to you.

Your consent applies to all recommended doses of COVID-19 vaccine.

If the user 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 the user may be vaccinated against COVID-19.

You may change your consent at any time.

☐ I CONSENT to have the user vaccinated against COVID-19.

☐ I DECLINE to have the user vaccinated against COVID-19.

☐ DOES NOT APPLY because the user has already been vaccinated against COVID-19.

Parent's or Legal representative signature:		**Date**	Year	Month	Day