



DT9593

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

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"/> Legal representative	
Area code	Home phone no.	Area code	Other phone no.
		<input type="checkbox"/> Cell	<input type="checkbox"/> 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: <ul style="list-style-type: none"> 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.	<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.	Pregnancy If the patient is a woman, is she pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<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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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
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