FORT WILLIAM FIRST NATION
COVID-19 VACCINE PROGRAM
PRE-REGISTRATION

Fort William First Nation will be hosting a Vaccine clinic to distribute the 1st of two vaccine doses of the COVID 19 Vaccination. Registration for the 1st dose will be required to plan the number of vaccines needed during the clinic.

Registration for the 1st dose can be done by

- Calling the COVID-19 hotline at 698-0415 **or**
- emailing covid19@fwfn.com

The COVID 19 Hotline will be accepting registrations during the weekend to accommodate the need for registration.

The Vaccine schedule will be done by priority based on listed criteria
Fort William First Nation registered members 55+
Individuals with underlying health issue and/or disability
Fort William First Nation Members 16+
Community Members 16+

You will be contacted for an appointment

For those that register and attend their scheduled appointment there will be a draw for prizes.

Please see the attached registration and consent form for what information will be required when you attend the clinic.

PLEASE REGISTER AS SOON AS POSSIBLE

COVID-19 Vaccine Screening and Consent Form

SCREENING AND CONSENT FORM –COVID-19 Vaccine

Version 2.0 – January 23, 2021

Last Name	First Name		Identification (e.g., health card number)	
Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Prefer not to answer			Primary Care Clinician (Family Physician or Nurse Practitioner)	
Home Phone	Mobile Phone	Email Address		
Street Address		City	Province	Postal Code
Date of Birth (month, day, year) _____ / _____ / _____	Age	Is this your **first or second dose** of the vaccine? ☐ First ☐ Second If second, please indicate the date of the first dose: _____ / ____ / ____ (month, day, year)		

Please answer all questions below:

Do you have symptoms of COVID-19 or feel ill today*?, ☐ No ☐ Yes	If yes, please provide details
Have you previously had a severe allergic reaction (e.g., anaphylaxis) to a previous dose of a COVID mRNA vaccine or to any of its components or its container? ☐ No ☐ Yes	If yes, please provide details
Do you have a suspected hypersensitivity or have you had an immediate allergic reaction *(this would include an allergic reaction that occurred within 4 hours that cause hives, swelling, or respiratory distress, including wheezing)* **to:**	If yes, please provide details
• **A previous dose of an mRNA COVID-19 vaccine** ☐ No ☐ Yes	
• **Any components of the mRNA COVID-19 vaccine (including polyethylene glycol [PEG])**** ☐ No ☐ Yes	
• **Polysorbate (due to potential cross-reactive hypersensitivity with the vaccine ingredient PEG)**** ☐ No ☐ Yes	

Have you ever had a severe (e.g. anaphylaxis) or an immediate allergic reaction to any other vaccine or injectable therapy (e.g. intramuscular, intravenous, or subcutaneous vaccines or therapies not related to a component of mRNA COVID-19 vaccines or polysorbates)? *(this would include an allergic reaction that occurred within 4 hours that cause hives, swelling, or respiratory distress, including wheezing)* ☐ No ☐ Yes	If yes, please provide details
Have you ever had a severe allergic reaction (e.g., anaphylaxis) not related to vaccines or injectable medications – such as allergies to food, pet, venom, environmental, or latex etc.? ☐ No ☐ Yes	If yes, please provide details
Have you received another vaccine (not a COVID-19 vaccine) in the past 14 days? ☐ No ☐ Yes	If yes, please provide details
Are you or could you be pregnant? ☐ No ☐ Yes	If yes, please provide details
Are you breastfeeding? ☐ No ☐ Yes	If yes, please provide details
Do you have any problems with your immune system or are you taking any medications that can affect your immune system (e.g., high dose steroids, chemotherapy)? ☐ No ☐ Yes	If yes, please provide details
Do you have an autoimmune disease? ☐ No ☐ Yes	If yes, please provide details
Do you have a bleeding disorder or are taking medications that could affect blood clotting (e.g., blood thinners)? ☐ No ☐ Yes	

Have you ever felt faint or fainted after a past vaccination or medical procedure? ☐ No ☐ Yes	If yes, please provide details

* Symptoms of COVID-19 can include fever, new onset of cough or worsening of chronic cough, shortness of breath, difficulty breathing, sore throat, difficulty swallowing, decrease or loss of smell or taste, chills, headaches, unexplained tiredness / malaise / muscle aches, nausea / vomiting, diarrhea or abdominal pain, pink eye, or runny nose or nasal congestion without other known cause or, for those over 70 years of age...an unexplained or increased number of falls, acute functional decline, worsening of chronic conditions or delirium	** Polyethylene glycol (PEG) can rarely cause allergic reactions and is found in products such as medications, bowel preparation products for colonoscopy, laxatives, cough syrups, cosmetics, skin creams, medical products used on the skin and during operations, toothpaste, contact lenses and contact lens solution. PEG also can be found in foods or drinks, but is not known to cause allergic reactions from foods or drinks. Polysorbate may also cause allergic reactions because of cross-reactivity with PEG.

Consent to Receive the Vaccine

I have read (or it has been read to me) and I understand the 'COVID-19 Vaccine Information Sheet'

- I have had the opportunity to ask questions and to have them answered to my satisfaction.
- I have had the opportunity to speak with my primary care provider regarding any special considerations that apply to me in respect of the COVID-19 vaccine.

☐ **I consent to receiving the vaccine**

Acknowledgement of Collection, Use and Disclosure of Personal Health Information

The personal health information on this form is being collected for the purpose of providing care to you and creating an immunization record for you, and because it is necessary for the administration of Ontario's COVID-19 vaccination program. This information will be used and disclosed for these purposes, as well as other purposes authorized and required by law. For example,

- it will be disclosed to the Chief Medical Officer of Health and Ontario public health units where the disclosure is necessary for a purpose of the *Health Protection and Promotion Act*. And
- it may be disclosed, as part of your provincial electronic health record, to health care providers who are providing care to you.

The information will be stored in a health record system under the custody and control of the Ministry of Health.

Where a Clinic Site is administered by a hospital, the hospital will collect, use and disclose your information as an agent of the Ministry of Health.

☐ **I acknowledge that I have read and understand the above statement.**

You may be contacted by a hospital, local public health unit, or the Ministry of Health for purposes related to the COVID-19 vaccine (for example, to remind you of follow up appointments and to provide you with proof of vaccination). If you consent to receiving these follow up communications by email or text/SMS, please indicate this using the boxes below.

I consent to receiving follow-up communications:
☐ **by email** ☐ **by text/SMS**

Consent to Being Contacted About Research Studies

Many research studies will be conducted in respect of COVID-19 vaccines.

You have the option of consenting to be contacted by researchers about participation in COVID-19 vaccine related research studies. If you consent to be contacted, your personal health information will be used to determine which studies may be relevant to you, and your name and contact information will be disclosed to researchers. Consenting to be contacted about research studies does not mean you have consented to participate in the research itself. Participating in research is voluntary. You may refuse to consent to be contacted about research studies without impacting your eligibility to receive the COVID-19 vaccine.

If you consent to be contacted about research studies, and then change your mind, you may withdraw your consent at any time by contacting the Ministry of Health at Vaccine@ontario.ca.

I consent to be contacted about COVID-19 vaccine related research studies:

☐ **by email** ☐ **by text/SMS** ☐ **by phone** ☐ **by mail**

☐ **I do not consent to be contacted about COVID-19 related research studies:**

Signature	Print Name	Date of Signature

If signing for someone other than yourself, indicate your relationship to that other person:

_____

☐ If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker.

Specific Issues re: Long-Term Care Homes Act, 2007

The resident's consent to receive the vaccine may be withdrawn or revoked at any time.

Statement respecting section 83 of the Act:

Please note the following legal protection:

Every licensee of a long-term care home shall ensure that no person is told or led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because,

(a) a document has not been signed;
(b) an agreement has been voided; or
(c) a consent or directive with respect to treatment or care has been given, not given, withdrawn or revoked.

FOR CLINIC USE ONLY						
Agent	COVID-19	Product Name		Lot #		Dose
Anatomical Site	☐ Left deltoid ☐ Right deltoid			Route	Intramuscular	Dose #
Date Given	____ / ____ / ____ (m/d/yyyy)		Time Given	____ : ____ am pm	AEFI?	☐ Yes ☐ No
Given By (Name, Designation)			Location		Authorized By	
Reason for Immunization	☐ Healthcare worker ☐ Healthcare worker: LTC Home ☐ Healthcare worker: Retirement Home ☐ LTC Home: Resident ☐ Retirement Home: Resident ☐ Advanced age: community dwelling ☐ Other employees in acute care, LTC, RHs ☐ Indigenous community ☐ Chronic conditions					
Reason Immunizations Not Given	Healthcare provider: ☐ Determines immunization is contraindicated ☐ Recommends immunization but no consent received ☐ Determines that immunization will be temporarily deferred					
Your dose 2 of 2 is scheduled for:	____ / ____ / ____ (m/d/yyyy)		____ : ____ am pm			