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| Ministry of Health | Ministry of Health (Ontario) - Wikipedia |
| **COVID-19 Vaccine Data Entry Form (AstraZeneca)**  | Version 1 – March 3, 2021 |
|  |  |
| **CLIENT INFORMATION** |
| Last Name | First Name | Date of Birth (month, day, year) |
|  |  |  | |  |
| Street | City | Province | Postal Code |
|  |  | ON |  |
| Home phone | Mobile Phone | Email |
|  |  |  |
| Employer **or** Long-Term Care Home/Retirement Home Name (if resident) | Ontario Health Card Number |
|  |  |
| Alternate ID | Alternate ID Type |
|  | [ ]  Birth Certificate [ ]  Employee ID [ ]  First Nation [ ]  Passport [ ]  MRN [ ]  Out of province Health Card # [ ]  Driver’s license  |
| Gender  | [ ]  Male [ ]  Female [ ]  Non-binary/Third Gender [ ]  Other [ ]  Prefer not to say [ ]  Unknown |
| **PROXY INFORMATION** |
| Last Name | First Name | Phone |
|  |  |  |
| Relationship to Client | [ ]  Child [ ]  Friend [ ]  Grandparent [ ]  Parent [ ]  Roommate [ ]  Spouse/Partner [ ]  POA [ ]  SDM [ ]  Other |
| **CONSENT** |
| [ ]  Consent to data collection[ ]  Consent to receive the vaccine | Consent to receive communications via:[ ]  Email [ ]  Text/SMS | Consent to receive comms regarding COVID research via:[ ]  Email [ ]  Text/SMS |
| **ADMINISTERED DOSE \*\*\* For Clinic Use Only \*\*\*** |
| Agent | COVID-19 | Anatomical Site | [ ]  Left deltoid [ ]  Right deltoid |
| Product Name | ASTRAZENECA COVID-19 | Route | Intramuscular |
| Lot # |  | Dose # | 1 of 2 |
| Dose | 0.5 ml | AEFI? | [ ]  Yes  |
| Date Given | February \_\_\_\_\_\_\_, 2021 | Time Given | \_\_\_\_ : \_\_\_\_ am pm |
| Given By |  | Location |  |
| Reason for Imms | [ ]  Healthcare worker [ ]  Healthcare worker: Long term care [ ]  Healthcare worker: Retirement home [ ]  Long Term Care: Other Employee[ ]  Retirement Home: Other Employee  | [ ]  Long term care: Resident [ ]  Long term care: Essential Caregiver[ ]  Long term care: Other Non-Employee[ ]  Retirement home: Resident [ ]  Retirement home: Essential Caregiver[ ]  Retirement home: Other Non-Employee  | [ ]  Advanced age: Community dwelling [ ]  Indigenous community [ ]  Adult of chronic health care [ ]  Other priority population  |
| Reason Imms Not Given | [ ]  Healthcare provider determines immunization is contraindicated [ ]  Healthcare provider determines that immunization will be temporarily deferred[ ]  Healthcare provider rrecommends immunization but no consent received  | [ ]  Medically Ineligible [ ]  Deceased[ ]  Moved Out of Province  |
| Client’s dose 2 of 2 is scheduled for: | \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ (month, day, year) \_\_\_\_\_\_ : \_\_\_\_\_\_ am pm |
| **Vaccinator:** Please copy relevant information from above into the receipt below, then tear off the receipt and provide to the client. |
|  |
| **Ministry of Health / ministère de la Santé** | Ministry of Health (Ontario) - Wikipedia |
| Name/Nom: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Health Card Number/Numéro de la carte Santé: | # # # # # # \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ |
| Date of Birth/Date de naissance: | \_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_ (month / day/ year) |
| Date/Date: | \_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_ (month / day/ year) \_\_\_\_\_\_\_ : \_\_\_\_\_\_\_ am pm |
| Agent: | COVID-19 |
| Product Name/Nom du produit: | ASTRAZENECA COVID-19  |
| Lot/Lot: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dose/Dose: | 0.5 ml |
| Route/Voie: | Intramuscular / intramusculaire |
| Site/Site: | [ ]  Left deltoid / deltoide gauche [ ]  Right deltoid / deltoide droit |
| Dose/Dose | 1 of 2 |
| Administered By/Administré par: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Location/Lieu: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Your dose 2 of 2 is scheduled for/Votre 2e dose est prévue pour: | \_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_ (month / day/ year) \_\_\_\_\_\_\_ : \_\_\_\_\_\_\_ am pm |