|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Ministry of Health | | | | | | | | | | | | | | | | | | Ministry of Health (Ontario) - Wikipedia | | | | |
| **COVID-19 Vaccine Data Entry Form (Pfizer)** | | | | | | | | | | | | | | | | | Version 1.9 – 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 | PFIZER-BIONTECH COVID-19 mRNA | | | | | Product Name | | | | Pfizer Diluent Sodium Chloride | | | | | | | Route | | | | Intramuscular | |
| Lot # |  | | | | | Lot # | | | |  | | | | | | | Dose # | | | | 1 of 2 | |
| Dose | 0.3 ml | | | | | Dose | | | | 0.9% | | | | | | | 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: | | | | | | | PFIZER-BIONTECH COVID-19 mRNA | | | | | | | | | | | | | | | |
| Lot/Lot: | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| Dose/Dose: | | | | | | | 0.3 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 | | | | | | | | | | | | | | | |