BRITISH COLUMBIA | Ministry of Health

CONSENT FOR COVID-19 IMMUNIZATION

Last Name	First Name	School (if applicable)	Div / Teacher (if applicable)
Gender (specify) / Birthdate (YYYY / MM / DD)	Personal Health Number (PHN)	Name of Parent / Guardian / Representative	Relationship to Child
Home Phone / Cell Phone	ALERT	Has your child ever had a serious or life-threatening allergic reaction? ◯ No ◯ Yes (to what?)	
Alternate Phone(s)	ALERT	Is your child's immune system affected by a severe disease or medication? ◯ No ◯ Yes	

PARENT / GUARDIAN / REPRESENTATIVE – For the vaccine listed below, check Yes or No, sign and date.
I understand the information in the HealthLinkBC File ((https://www.healthlinkbc.ca/healthlinkbc-files/covid-19-vaccines) for the vaccine listed below. I understand the benefits and possible reactions for the vaccine and the risk of not getting immunized. I understand that in the rare occurrence of anaphylaxis, emergency treatment will be provided. I have had the opportunity to ask questions that were answered to my satisfaction. I understand this consent is valid for two years for the vaccine listed below unless I cancel it.

Mature Minor Consent: Parents/guardians and representatives should make every effort to discuss the information in the HealthLinkBC File (https://www.healthlinkbc.ca/healthlinkbc-files/covid-19-vaccines) for the vaccine listed below with the child, and to involve the child as much as possible in the decision to provide consent to immunization. Although a child may be immunized with the consent of a parent/guardian or representative, a child is entitled to be informed about immunization and may provide consent to immunization if the person administering the vaccine is sure that the child understands the benefits of, and possible reactions to, the vaccine, and the risk of not getting immunized.

PARENT / GUARDIAN / REPRESENTATIVE USE ONLY		PUBLIC HEALTH USE ONLY – CHILD'S IMMUNIZATION RECORD				
COVID-19 Vaccine						
If your child has received one or more doses of COVID-19 vaccine, please give brand name and date(s):			Date YYYY / MM / DD	Site	Lot #	Health Care Provider Signature
Vaccine Dose #1 Brand Name	YYYY / MM / DD	1ST Dose		◯ LA ◯ RA		
Vaccine Dose #2 Brand Name	YYYY / MM / DD	2ND Dose		◯ LA ◯ RA		
I want my child immunized: ◯ **Yes** ◯ **No**		Health Care Provider Notes				
Signature	Date (YYYY / MM / DD)					

PUBLIC HEALTH USE ONLY – MATURE MINOR CONSENT		
I want to be immunized for COVID-19: ◯ **Yes** ◯ **No** **Child Signature:**	Health Care Provider Signature	Date (YYYY / MM / DD) Time ◯ AM ◯ PM

PUBLIC HEALTH USE ONLY – TELEPHONE CONSENT			
Telephone Consent Obtained From	For: **COVID-19 Vaccine** ◯ **Yes** ◯ **No**	Phone Number Called	Date (YYYY / MM / DD)
Relationship to Child		Health Care Provider Signature	Time ◯ AM ◯ PM

Personal information collected on this form will be used by the health authority to update the child's immunization record. The information will be used and disclosed in accordance with the *Freedom of Information and Protection of Privacy Act*. Summary statistical information may be reported to the Ministry of Health. If you have any questions about the collection and use of this personal information, contact your local public health nurse.

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