Report of COVID19 Vaccination (ver. 2.0)

CLIENT TO FILL IN

Last Name	**First Name**	
Sex ☐ Male ☐ Female ☐ X	**Birthdate (YYYY/MMM/DD)**	
Care Card Number / PHN	**Phone**	
Address	**City**	**Postal Code**
I identify as an indigenous person ☐ Yes ☐ No ☐ Choose not to answer		

Clinician to Complete Remainder of Form

CONSENT / DISSENT

Effective From (date)			**Consent**
YYYY	**MMM**	**DD**	☐ Consented ☐ Refused
			If Refused, reason for refusal:
Given / Refused By ☐ Client ☐ Substitute Decision Maker ☐ Other If other, specify: _____			**Method of Consent** ☐ In Person ☐ Telephone ☐ Written
Name and Relationship of Person Providing/Refusing Consent (if not client):			**Consent Obtained By:**

IMMUNIZATION

Date of Vaccination *(e.g. 2020 Jan 31)*			**Agent**	**Lot Number**	**Body Site**
YYYY	**MMM**	**DD**			
			☐ **Pfizer mRNA BTM162b2** ☐ **Moderna mRNA-1273**		☐ Left Arm ☐ Right Arm
Facility Name					
Reason for Immunization ☐ Resident – Long Term Care ☐ Resident – Assisted Living	☐ Staff – Long Term Care ☐ Staff – Assisted Living	☐ Staff – Pandemic Support ☐ Staff – Hospital	☐ Physician ☐ Paramedic	☐ Other	
Administered By (print name)	**Signature**			**Designation**	

Allergies	**Risk Factors**	
Immunization Notes		
Documented By (print name)	**Signature**	**Designation**

*** Adverse Events require completion of the PHAC AEFI form and submission to Public Health ASAP**

****All information on this form must be documented into Fraser Health Paris as soon as possible.**