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Department of Health
Munaqhiiliqiyitkut
Ministère de la Santé

COVID-19 Vaccine Consent Form

Please fill in OR affix label:

Last Name: _____
First Name: _____
Community: _____
DOB (dd/mm/yyyy): _____
HCP#: _____

Phone number: _____

Email address (optional): _____

House number (optional): _____

Parent/guardian information

Name: _____ Phone: _____

Based on the age of the vaccine recipient and COVID-19 immunization history it is recommended that you/your child/ward receive the following immunization:

- Pfizer BioNTech Comirnaty (ORIGINAL) – 6mos to <5yrs
- Pfizer BioNTech Comirnaty (ORIGINAL) – 5yrs to <12yrs
- Pfizer BioNTech Comirnaty (BIVALENT) – 5yrs to <12yrs
- Pfizer BioNTech Comirnaty (ORIGINAL) –12yrs+
- Pfizer BioNTech Comirnaty (BIVALENT) –12yrs+
- Other: _____

Consent for COVID-19 Vaccine:

- I understand the information in the Information Sheet on the COVID-19 Vaccine.
- I understand the benefits and possible reactions for the COVID-19 Vaccine and the risk of not getting immunized.
- I have had the opportunity to ask questions and to have them answered to my satisfaction.
- I consent to the COVID-19 vaccine being given to: My Child, My Ward or Myself

Print Name

Signature of Client or Parent/Legal Guardian

Date (dd/mm/yyyy)