ᐊᓐᓄᓗᒃ
Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

Pediatric Moderna SPIKEVAX® COVID-19 Vaccine Consent Form

Please fill in or put label:

Last Name_____

First Name_____

Community_____

DOB (dd/mm/yyyy)_____

Please ensure name, community, and date of birth are completed above.

Health card number (if known): _____ **House number (optional):** _____

Phone number: _____ **Email address (optional)**: _____

Gender: Man ☐ Woman ☐ Prefer to self-describe ☐ _____ **Age:** _____

Parent/guardian information

Name: _____ **Phone:** _____

For the person receiving the vaccine (guardians to answer on child's behalf), please answer:

Is this your child's first, second, or third dose of the Moderna vaccine? ☐ 1st ☐ 2nd ☐ 3rd

*3rd dose only available for individuals with moderate-severe immunocompromise.

*It is recommended that doses are delayed for 3 months after COVID-19 infection. Please refer to the Nunavut Pediatric Moderna SPIKEVAX® protocol for more information.

If second or third dose, what date was the previous dose? _____ *dd / mm / yyyy* _____

		Yes	No
1.	**Does your child feel sick with a fever today?** (If yes, please provide details below.)	☐	☐
2.	**Have you or your child had COVID-19?** (If yes, please indicate when symptoms started below) *You can still receive the vaccine if you've had or think you've had COVID-19 before.*	☐	☐
3.	**If this is your child's second or third dose, did they have any side effects after any previous doses?** (If yes, please provide details below.)	☐	☐
4.	**Does your child have any problems with their immune system or are they taking any medications that can affect their immune system (e.g., high dose steroids, chemotherapy)?** (If yes, please provide details below.)	☐	☐
5.	**Does your child have a bleeding disorder or are they taking any medications that could affect blood clotting?** (If yes, please provide details below.)	☐	☐
6.	**Has your child had a serious reaction to a vaccine in the past?** (If yes, please provide details below.)	☐	☐
7.	**Is your child allergic to polyethylene glycol (PEG)** or tromethamine which are ingredient(s) in the vaccine?**	☐	☐
8.	**Has your child ever had a severe allergic reaction for which they were prescribed an Epipen?** (If yes, please provide details below.)	☐	☐
9.	**Has your child ever been diagnosed with myocarditis or pericarditis**** following administration of a COVID-19 vaccine?** (If yes, please do not proceed with vaccination today).	☐	☐

** Polyethylene glycol (PEG) can rarely cause allergic reactions and is found in products such as medications, bowel preparation products for colonoscopy, laxatives, cough syrups, cosmetics, skin creams, medical products used on the skin and during operations, toothpaste, contact lenses and contact lens solution. Tromethamine (Tris) is found in contrast media, oral and parenteral medications.

**** Very rare cases of myocarditis and pericarditis following vaccination with mRNA vaccines have been reported. The decision to continue a COVID-19 vaccine series in individuals with a history of myocarditis or pericarditis should be made by the office of the Chief Public Health Officer.

ᐊᓐᓄᓗᒃ
Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

Pediatric Moderna SPIKEVAX® COVID-19 Vaccine Consent Form

Please fill in or put label:

Last Name_____

First Name_____

Community_____

DOB (dd/mm/yyyy)_____

Comments from questions above:

CONSENT FOR Moderna COVID-19 Vaccine:

For additional information about mature minors please refer to Appendix C and Section 3.2.3 of the Nunavut Immunization Manual.

- I understand the information in the Information Sheet on the Moderna COVID-19 Vaccine.
- I understand the benefits and possible reactions for the Moderna 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 Moderna being given to: My Child ☐ My Ward ☐ or Myself ☐

_____ **Print Name**

Signature of Client or Parent/Legal Guardian **Date (dd/mm/yyyy)**

Additional questions to help understand the population receiving the vaccine

Risk Group *Tick all that apply*			**Yes**	**No**
Living in a shelter			☐	☐
Underlying medical condition: *If yes, circle all those that apply in the list the below*				
heart disease	lung disease	cancer		
high blood pressure	diabetes	problems with your immune system	☐	☐
kidney disease	liver disease	taking medication that affects immune system		

ᐊᓐᓄᑦ
Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

Pediatric Moderna SPIKEVAX® COVID-19 Vaccine Consent Form

Please fill in or put label:

Last Name_____

First Name_____

Community_____

DOB (dd/mm/yyyy)_____

For Administrative Use Only:

	DOSE	LOT #	SITE & ROUTE	GIVEN BY & WHEN Name and designation/Date and time
1st Dose	**0.25 mL**			**Name:**
				Date: *dd / mm / yyyy* **Time:**
2nd Dose	**0.25 mL**			**Name**
				Date: *dd / mm / yyyy* **Time:**
3rd Dose (if eligible)	**0.25 mL**			**Name:**
				Date: *dd / mm / yyyy* **Time:**

Comments: