Alberta Health Services

COVID-19 School Immunization Consent

To have your child immunized at school for COVID-19, please **read the attached COVID-19 vaccine information sheet, complete this form,** and **return it** to your child's school. NOTE: this form must be completed by a parent or guardian.

Child's personal information

Child's Name *(Last, First, Middle)*	Date of Birth *(dd-Mon-yyyy)*	
Personal Health Number (PHN)	Gender	
School	Grade	Client/Unit ID # *(For Office Use Only)*

Child's health information *(If you need more space, use the other side of this form.)*

Does your child have any allergies, including allergies to any vaccine, medicine, or food? ☐ No ☐ Yes
If yes, describe ______________________________

Has your child had a COVID-19 vaccine before? ☐ No ☐ Yes If yes, when ______________________________

Has your child ever had a side effect from COVID-19 immunization? ☐ No ☐ Yes
If yes, describe ______________________________

Consent

I confirm that I have read the attached COVID-19 vaccine information. I know about and understand the risks, benefits, and common side effects of this vaccine. Any questions I may have had about my child getting this vaccine have been answered by calling the local public health office or Health Link at 811. I understand the information I have been given.

I understand this consent is for a dose of the COVID-19 vaccine. I will contact the local public health office or the nurse for the school if my child:

- has any changes to their health before getting the COVID-19 vaccine
- gets another vaccine in the 14 days before they get the COVID-19 vaccine
- has a severe or unusual side effect after the first dose of the COVID-19 vaccine (other than the expected side effects listed on the COVID-19 vaccine information sheet)

I consent to my child getting thePfizer-BioNTech mRNA COVID-19 vaccine.

I understand that I may withdraw this consent at any time by calling the local public health office or the nurse for the school.

I confirm that I have the legal authority to consent to this immunization.

Printed name of person giving consent	Daytime phone	Other phone

Relationship to person
☐ Parent (with legal authority to consent) ☐ Guardian
☐ Other ______________________________

Signature of person giving consent	Date (dd-Mon-yyyy)

Alberta Health Services collects health information according to Section 20 of the Health Information Act (HIA). This information is used to provide health services, determine eligibility for health services, or to carry out any other purpose authorized by the HIA. If you have any questions about this, please ask the healthcare provider giving the immunization or contact your local public health office. If you do not know your local public health office,call Health Link at 811 to get this information.

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Child's Name *(Last, First, Middle)*				PHN
Telephone/Fax Consent				
Mode by which consent was received	☐ Fax/Scan	☐ Telephone		
Name of healthcare provider obtaining the consent		Date *(dd-Mon-yyyy)*	Time	
Signature of healthcare provider obtaining the consent				
Consent Using an Interpreter *(for non-English speaking parent/client)*				
Interpreter's name or ID #	Phone	Date *(dd-Mon-yyyy)*	Time	
Notes *(For Office Use Only)*				