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Santé et Services sociaux Québec

DT9593

CONSENT FOR VACCINATION AGAINST COVID-19 FOR USERS UNDER THE AGE OF 14

User's last and first name

Mother's last and first name

Father's last and first name (optionnal)

Date of birth Year Month Day Sex ☐ M ☐ F

Health insurance number (if available) Expiry date Year Month

Address (number, street)

City Postal code

GENERAL INFORMATION

Name of school:	Class:
Authorized person to consent to vaccination (last name, first name):	Status: ☐ Parental authority ☐ Guardian
Area code Home phone no.	Area code Other phone no. ☐ Cell ☐ Work
Email address:	

USERS UNDER AGE 14

(Written consent is not required for children age 14 and up, as they can provide their own consent for vaccination.)

PRE-IMMUNIZATION QUESTIONNAIRE

	QUESTIONS REGARDING YOUR CHILD'S HEALTH	YES	NO	N/A or IDK	DETAILS
1.	**Health problems** Do either of these situations apply to them: • They have had a positif test for COVID-19. • They have symptoms of COVID-19. • You have noticed a recent change in their condition (e.g., appearance of unusual symptoms). • They have a health condition that requires medical monitoring or regular medication. If either of these situations apply, please indicate details.	☐	☐	☐	
2.	**Immunosuppression** Do either of these situations apply to them: • They take immunosuppressant drugs. • They have a disease that weakens the immune system, like cancer. If either of these situations apply, please indicate the drug or disease.	☐	☐	☐	
3.	**Previous reactions** Have they ever had a significant reaction (other than a food, seasonal, or pet allergy) after receiving a vaccine or other product that required a visit at the hospital? If yes, please tell us what product caused this reaction.	☐	☐	☐	
4.	**Bleeding disorder** Do they have or have they had a blood clotting disorder (e.g., thrombosis, thrombocytopenia) requiring medical attention or are they taking an anticoagulant?	☐	☐	☐	
5.	**Immunization or blood products** Do either of these situations apply to them: • They have received a vaccine in the last 14 days. • They have been hospitalized for COVID-19 treatment in the last 90 days. If either of these situations apply, please indicate the treatment or vaccine.	☐	☐	☐	

Legend:
N/A : Not applicable
IDK: I don't know

User's last and first name	Record no.

PARENT/GUARDIAN CONSENT (DECISION)

As the parent or guardian of a child under the age of 14, you are in charge of vaccination decisions for this child.

Explanations to help you make an informed decision are provided in the leaflet attached to this form.

Your consent applies to 2 doses of COVID-19 messenger RNA vaccine (Pfizer).

If your child has already had positive test to COVID-19, the vaccinator will assess them and then administer the required number of doses; only one dose may be required.

Indicate whether or not your child may be vaccinated against COVID-19 with Pfizer RNA COVID-19 vaccine.

You may change your consent at any time.

☐ I CONSENT to have my child vaccinated against COVID-19.

☐ I DECLINE to have my child vaccinated against COVID-19.

☐ DOES NOT APPLY because my child has already been vaccinated against COVID-19.

Parent's or guardian's signature:		**Date**	Year	Month	Day