



Health PEI Employee Employee # _____ Work site: _____ Department: _____
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## COVID Immunization Clinic Registration Form

Date of Clinic: \_\_\_\_\_ Location of Clinic: \_\_\_\_\_

Client Name: \_\_\_\_\_ Health Card #: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Civic Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

<p><b>Target Population:</b> <i>select all groups to which you belong</i></p> <p><input type="checkbox"/> Health Care Worker with direct or indirect patient care</p> <p><input type="checkbox"/> Congregate living setting for seniors – resident</p> <p><input type="checkbox"/> Partner in Care for senior in congregate living setting</p> <p><input type="checkbox"/> Other congregate living settings – resident or staff</p> <p><input type="checkbox"/> Older adult (70+)</p> <p><input type="checkbox"/> Mi'kmaq on reserve communities</p> <p><input type="checkbox"/> Indigenous off reserve communities</p> <p><input type="checkbox"/> Non-health Essential Worker 1 (e.g. police, firefighter, armed forces, deployed personnel, registered rotational workers, truck drivers)</p> <p><input type="checkbox"/> Non-health Essential Worker 2 (e.g. transportation worker, grocery store worker, agricultural worker)</p> <p><input type="checkbox"/> Person with underlying medical condition(s) or their family</p> <p><input type="checkbox"/> School student</p>	<p><b>Ethnicity:</b> <i>can be one to many</i></p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Black</p> <p><input type="checkbox"/> East/Southeast Asian</p> <p><input type="checkbox"/> Indigenous</p> <p>If Indigenous, to which do you identify:</p> <p><input type="checkbox"/> First Nations</p> <p><input type="checkbox"/> Métis</p> <p><input type="checkbox"/> Inuk/Inuit</p> <p><input type="checkbox"/> Other, specify: _____</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Prefer not to say</p> <p>If First Nations, which community:</p> <p><input type="checkbox"/> Abegweit First Nation/ Epekwitk</p> <p><input type="checkbox"/> Lennox Island First Nation/ L'nui Mnikuk</p> <p><input type="checkbox"/> Other, specify: _____</p> <p><input type="checkbox"/> Prefer not to say</p>
<p><b>Health Conditions:</b> <i>can be one to many</i></p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Chronic Respiratory Disease (i.e. COPD, asthma)</p> <p><input type="checkbox"/> Cardiovascular Disease i.e. hypertension, ischemic heart disease, heart failure, stroke</p> <p><input type="checkbox"/> Neurological Disease i.e. dementia, MS, epilepsy, Parkinson's disease</p> <p><input type="checkbox"/> Cancer</p>	<p><input type="checkbox"/> Latino</p> <p><input type="checkbox"/> Middle Eastern</p> <p><input type="checkbox"/> South American</p> <p><input type="checkbox"/> South Asian</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Other, specify: _____</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Prefer not to say</p>

### Part 1: To be completed by Client/Parent/Guardian:

I have read or have had the information sheets about the COVID 19 immunization read to me and understand the information about the immunization that will be received by the above named individual. The nature and anticipated effect of this immunization including the risks and benefits have been explained to me and I am satisfied with these explanations and I understand them. I have had the opportunity to ask questions and have them answered. I consent to receiving this immunization and any follow up immunizations that may be required.

Print name (client/parent/guardian) \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship to the client: \_\_\_\_\_

*\*See Reverse for Additional Details*

### Part 2: To be completed by Nurse: Nurse Screening

Are you sick? Do you have any symptoms of COVID 19? Yes  No   
Do you have any allergies? Yes  No   
Any previous severe or anaphylactic reaction to a vaccine? Yes  No   
Are you immunosuppressed due to disease or treatment? Yes  No   
Are you pregnant or breastfeeding? Yes  No   
Have you received a vaccine in the past 14 days? Yes  No

**DOSE #** \_\_\_\_\_ **VACCINE ADMINISTRATION DATE:** \_\_\_\_\_

**Pfizer/BioNTech** 0.3mL  Site: IM Deltoid Right  Left  Lot # \_\_\_\_\_  
Expiry Date: \_\_\_\_\_ Nurse Administering: \_\_\_\_\_

**Moderna** 0.5mL  Site: IM Deltoid Right  Left  Lot # \_\_\_\_\_  
Expiry Date: \_\_\_\_\_ Nurse Administering: \_\_\_\_\_

Moderna 0.25mL  Site: IM Deltoid Right  Left  Lot # \_\_\_\_\_  
Expiry Date: \_\_\_\_\_ Nurse Administering: \_\_\_\_\_

Personal health information on this form is collected for the purposes of the provision of health care. Your information will be collected, used, and disclosed only as permitted by the *Health Information Act, RSPEI 1988, c H-1.41*, and other applicable legislation. For more information on privacy and your personal health information, visit [www.healthpei.ca/yourprivacy](http://www.healthpei.ca/yourprivacy) or contact (902) 368-6157.

April 2022