Ministry of Health

Ontario

COVID-19 Vaccine Data Entry Form

Version 1.3 – December 31, 2020

CLIENT INFORMATION

Last Name		First Name
Ontario Health Card Number	Alternate ID	Alternate ID Type ☐ Birth Certificate ☐ Employee ID ☐ First Nation ☐ Passport ☐ MRN ☐ Out of province Health Card # ☐ Driver's license
Long-Term Care Home or Retirement Home Name (if applicable)		Gender ☐ Male ☐ Female ☐ Non-binary/Third Gender ☐ Other ☐ Prefer not to say ☐ Unknown
Date of Birth (month, day, year) _____ / ______ / ______	Age	Is this your **first or second dose** of the vaccine? ☐ First ☐ Second If second, please indicate the date of the first dose: _____ / ___ / ___ (month, day, year)

PROXY INFORMATION

Last Name	First Name	Phone
Relationship to Client:	☐ Child ☐ Friend ☐ Grandparent ☐ Parent ☐ Roommate ☐ Spouse/Partner ☐ Power of Attorney - POA ☐ Substitute Decision Maker - SDM ☐ Other	

CONSENT

☐ Consent to data collection

☐ Consent to receive the vaccine

Consent to receive communications: ☐ by email ☐ by phone/SMS

Consent to receive communications regarding COVID research: ☐ by email ☐ by phone/SMS

FOR CLINIC USE ONLY

Agent	COVID-19	Product Name	COVID-19 Moderna Vaccine Mod	Lot #		Dose	0.5 ml
Anatomical Site	☐ Left deltoid ☐ Right deltoid			Route	Intramuscular	Dose #	1 of 2
Date Given	_____ / _____ / _____ (m/d/yyyy)			Time Given	___ : ___ am pm	AEFI?	☐ Yes ☐ No
Given By (Name, Designation)		Location		Authorized By			

Reason for Immunization	☐ Healthcare worker ☐ Healthcare worker: LTC Home ☐ Healthcare worker: Retirement Home ☐ LTC Home: Resident ☐ Retirement Home: Resident ☐ Advanced age: community dwelling ☐ Other employees in acute care, LTC, RHs ☐ Indigenous community ☐ Adult of chronic health care
Reason Imms Not Given	Healthcare provider: ☐ Determines immunization is contraindicated ☐ Recommends immunization but no consent received ☐ Determines that immunization will be temporarily deferred
Your dose 2 of 2 is scheduled for:	_____ / _____ / _____ (month, day, year) _____ : _____ am pm

Vaccinator: Please copy relevant information from above into the receipt below. Tear off the receipt and provide to the client.

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Ministry of Health / Ministère de la Santé

Ontario

Name/Nom: ________________________

Health Card Number/Numéro de la carte Santé: # # # # # # ______ ______ ______ ______

Date of Birth/Date de naissance: ________ / ________ / ________ (month / day/ year)

Date/Date: ________ / ________ / ________ (month / day/ year) ______ : ______ am pm

Agent: COVID-19

Product Name/Nom du produit: COVID-19 Moderna Vaccine Mod

Lot/Lot: ________________

Dose/Dose: 0.5 ml

Route/Voie: Intramuscular / intramusculaire

Site/Site: ☐ Left deltoid / deltoide gauche ☐ Right deltoid / deltoide droit

Dose/Dose 1 of 2

Administered By/Administré par: ________________________ , ____________

Location/Lieu: ________________________

Your dose 2 of 2 is scheduled for/ Votre 2e dose est prévue pour: ________ / ________ / ________ (month / day/ year) ______ : ______ am pm