ST. MICHAEL'S CATHOLIC SCHOOL – WALSH
972 ST. JOHN'S ROAD WEST
RR 2 SIMCOE, ON N3Y 4K1
519-426-5462

PRINCIPAL – MRS. M. PETRELLA

SECRETARY – MRS. E. MERTENS

January 27, 2022

Dear Parent or Guardian,

Re: Vaccine Clinics

Thank you for your ongoing support and partnership in helping us to keep our school open and safe for in-person learning. Toward this effort we are pleased to be able to invite you to participate in the following vaccination clinics for our students and their families.

Haldimand Norfolk Health Unit Vaccination Clinics		
Date	**Time**	**Location**
Friday, February 4, 2022	4:00 - 7:00 pm	Mapleview Elementary School 223 Fairview Ave W, Dunnville
Saturday, February 5, 2022	10:00 - 4:00 pm	Hagersville Secondary School (Go Vax Clinic) 70 Parkview Rd, Hagersville
Friday, February 11, 2022	4:00 - 7:00 pm	St Frances Cabrini School 373 Northern Ave, Delhi
Saturday, February 12, 2022	10:00 - 4:00 pm	Lakewood (Go Vax Clinic) 713 St George St, Port Dover
Friday, February 18, 2022	4:00 - 7:00 pm	Langton Public School 23 Albert St, Langton
Friday, February 25, 2022	4:00 - 7:00 pm	St Patrick's School 81 Orkney St E, Caledonia

The Ontario Medical Officer of Health and all local Medical Officers of Health confirm that vaccines are safe and continue to represent the most effective strategy to protect Ontarians from COVID-19. It is also important for the protection of our youngest children (0-4) years, who are not yet eligible for vaccine protection. You are encouraged to follow this link https://hnhu.org/book-your-covid-19-vaccination/ to register for a time at one of the clinics although walk ins will also be accepted.

If you are accompanying your child to the clinic there is no need to bring the consent form. If your child is attending with anyone other than a parent/guardian, the consent form, attached to this email, should be presented at the clinic.

Please note that if your child is already scheduled to receive a vaccine within the next 1-2 weeks, that appointment should be honoured. Please have your child attend their pre-booked vaccine appointment

Preparing Your Child for Vaccination

We understand you, or your child, may have questions about the vaccine. Please speak to your child about the many benefits of being vaccinated against COVID-19. If your child has a fear of vaccination, please visit your local Public Health Unit for additional resources.

If you have questions about COVID-19 vaccines for children and youth please visit Vaccine Information Sheet for Children for further information or COVID-19 Vaccine Consult Service to book a confidential phone appointment with a SickKids clinician.

Sincerely,

Mrs. M. Petrella

Ministry of Health

Ontario

COVID-19 Vaccine Children/ Youth (Age 5-17) Consent Form

Version 3.0 –November 22, 2021

Child/Youth Last Name:	Child/Youth First Name:	Child/Youth Identification number (e.g., health card number):

Child/Youth Gender: ☐ Female ☐ Male
☐ Prefer not to answer ☐ Other: _____

If Indigenous, please indicate Child/Youth's Indigenous identity:
☐ First Nations
☐ Métis (includes members of the Métis organization or Settlement)
☐ Inuk/Inuit
☐ Other Indigenous, specify: _____
☐ Prefer not to answer
☐ Unknown

Mobile Phone:	Parent/legal guardian phone:

Child/Youth's Primary Care Clinician (Family Physician, Pediatrician, or Nurse Practitioner):

Street Address:	City:	Province:	Postal Code:

Child/Youth Date of Birth:

_____ / _____ / _____
month day year

School the Child/Youth is currently attending:

_____

☐ Prefer not to answer
☐ Home school
☐ Unknown
☐ Not attending school

Has the Child/Youth previously received one or more doses of a COVID-19 vaccine? If yes, please complete the information below for all doses of vaccine received.

First Dose date: --------/----------/-------- (month, day, year)
First dose product name: _____

Second Dose date: --------/----------/-------- (month, day, year)
Second dose product name: _____

Consent to Receive the Vaccine

I have read (or it has been read to me) and I understand the Immunization Prepackage, including the following documents: 'COVID-19 Vaccine Information Sheet' or the 'COVID-19 Vaccine Information Sheet: For Children (age 5-11)' and What you need to know about your Covid-19 vaccine appointment. I have had the opportunity to ask questions regarding the vaccine and to have them answered to my satisfaction. I understand that I may withdraw this consent at any time.

☐ I consent to receiving all recommended doses in the vaccine series.

OR

☐ I am a consenting on the patient's behalf to receive all recommended doses in the vaccine series and I confirm that I am the patient's substitute decision maker (e.g., parent, legal guardian).

Note: Please contact the vaccination clinic if you no longer consent to receiving the vaccine. If consent has been withdrawn by a substitute decision maker of an individual who resides in a congregate setting, then the congregate setting must contact the local public health unit.

Acknowledgement of Collection, Use and Disclosure of Personal Health Information

The personal health information on this form is being collected in accordance with the *COVID 19, Vaccination Reporting Act, 2021* for the purpose of providing care and creating an immunization record, and because it is necessary for the administration of Ontario's COVID-19 vaccination program. This information will be used and disclosed for these purposes, as well as other purposes in accordance with the *Personal Health Information Protection Act, 2004* and as authorized and required by law. For example,

- it will be disclosed to the Chief Medical Officer of Health and Ontario public health units where the disclosure is necessary for a purpose of the *Health Protection and Promotion Act*. And
- it may be disclosed, as part of your provincial electronic health record, to health care providers who are providing care to you.

The information will be stored in a health record system under the custody and control of the Ministry of Health. Where a Clinic Site is administered by a hospital, the hospital will collect, use, and disclose your information as an agent of the Ministry of Health.

☐ **I acknowledge that I have read and understand the above statement.**

You may be contacted by a hospital, local public health unit, or the Ministry of Health for purposes related to the COVID-19 vaccine (for example, to remind you of follow up appointments, to provide you with a record of immunization). If you agree to receiving these follow up communications by email or text/SMS, please indicate this using the box below.

☐ **I consent to receiving follow-up communications:**

☐ **by email** ☐ **by text/SMS**

If you agreed to be contacted by email or text/SMS, please provide your email address or your text/SMS number: _____

Consent to Being Contacted About Research Studies

You have the option of consenting to be contacted about participation in COVID-19 vaccine related research studies/surveys. If you consent to be contacted, personal health information may be used and your name and contact information will be disclosed to researchers. Consenting to be contacted about research studies does not mean you have consented to participate in the research itself. You may refuse to be contacted about research studies without impacting eligibility to receive the COVID-19 vaccine. If you change your mind, you may withdraw consent at any time by contacting the Ministry of Health at vaccine@ontario.ca.

☐ **I consent to be contacted about COVID-19 vaccine related research studies:**

☐ **by email** ☐ **by text/SMS** ☐ **by phone** ☐ **by mail**

If selected by email, please provide your email address: _____

☐ **I do not consent to be contacted about COVID-19 related research studies**

Signature	Print Name	Date of Signature

☐ If signing for someone other than myself, I confirm that I am the substitute decision maker.

If signing for someone other than yourself, indicate your relationship to the person you are signing for: _____

FOR CLINIC USE ONLY			
Agent COVID-19	Product Name	Lot #	Dose Amount:
Anatomical Site ☐ Left deltoid ☐ Right deltoid	Route Intramuscular (IM)		Dose #:
Date Given _____ / _____ / _____ (mm/dd/yyyy)	Time Given ____ : ____ am pm		AEFI? (after receiving current dose) ☐ Yes ☐ No
Given By (Name, Designation)	Location		
Authorized By			
Reason for Immunization	☐ Child/Youth 5+ ☐ Age Priority Population – Age Eligible Population ☐ Other reason: _____		
Reason Immunization Not Given	☐ Immunization is contraindicated ☐ Practitioner recommends immunization but no PATIENT consent ☐ Practitioner decision to temporarily defer immunization ☐ Medically Ineligible ☐ Patient withdrew consent for series		
Your next dose is scheduled for:	_____ / _____ / _____ (mm/dd/yyyy) ____ : ____ am pm		