COVID-19 VACCINATION - CONSENT FORM FOR CHILDREN FROM 5 to 13 YEARS OLD

ᓄᕙᓐᓇᕐᔪᐊᒧᑦ-19 ᑲᐱᔭᐅᓂᖅ ᑕᑕᕐᓴᑕᐅᒥᐊᓚᒃ ᐊᖏᕈᑎᒃ ᐱᐊᓗᑦ ᑕᑕᕐᓴᑕᐅᒍᑎᖓ 5-ᓂᒃ (ᓯᑕᒪᓂᒃ) 13-ᒧᑦ (ᕿᓚᓪᓗ ᐱᖓᓱᓪᓗᒧᑦ) ᐅᑭᐅᓚᖕᓄᑦ

SECTION A – IDENTIFICATION OF CHILD | ᐊᕕᑦᑐᓯᒪᓂᖓ ᐊ–ᐱᐊᕋᐅᑉ ᓇᓗᓀᕐᑕᐅᓯᒪᐅᑎᖓ

LAST NAME | ᐊᑎᓚᕐᕿᖓ: ______________________________

FIRST NAME | ᐊᑎᖓ: ______________________________

DATE OF BIRTH | ᐃᓅᓚᕐᕕᖓᑕ ᐅᓪᓗᖓ: _____/_____/_____

GENDER | ᓇᓪᓚᐊᒍᓂᖓ: M | ᐊᖑᑎᒃ F | ᐊᕐᓇᖅ

NAMES OF PARENTS OR GUARDIAN | ᐊᖓᔪᕐᕿᖏᑦᑕ ᐊᑎᖏᑦ ᑫᑲᒪᔨᖏᑦᑕᓘᓐᓃᑦ0:

MOTHER | ᐊᓈᓇᖓ: ______________________________

FATHER | ᐊᑖᑕᖓ: ______________________________

GUARDIAN | ᑲᒪᔨᖏᑦᑕᓘᓐᓃᑦ: ______________________________

SECTION B – CHILD'S MEDICAL AND VACCINATION HISTORY | ᐊᕕᑦᑐᓯᒪᓂᖓ ᐸ– ᐱᐊᕋᐅᑉ ᐋᓐᓂᐊᓯᐅᕐᑕᐅᒍᑎᒥᓯᒪᔭᖏ

1. Do either of these situation apply to your child?
ᐅᑯᓂᖓ ᐅᕐᑲᕐᑕᐅᓯᒪᔪᓂᒃ ᐃᓚᐅᓕᕐᑎᑕᐅᓚᐅᕋᑕᕈᓇᑦᓴᕐᑐᖅ ᐱᐊᕈᑦ?

OUI | ᐋᐊ **NON** | ᐊᐅᑲ **NE SAIS PAS** | ᕐᑲᐅᔨᒪᖕᖏᑐᖓ

- He/She had COVID-19? | ᓄᕙᓐᓇᑖᕐᑐᕕᓂᐅᔫᓇᓱᕐᑐᖅ ᓄᓇᕙᓐᓇᖅ-19ᒥᒃ?
- He/She currently has symptoms of COVID-19? | ᐃᑉᐱᓂᐊᓂᕐᓂᖅᑲᕈᓇᑦᓱᑐᖅ ᓄᕙᓐᓇᖅ-19 ᐃᑉᐱᓂᐊᕈᓯᖓᓂᒃ?
- You have noticed a recent change in his/her state of health | ᐃᑉᐱᒍᓱᓚᐅᕋᑕᕈᓐᓇᓱᕐᕿᑦ ᐱᐊᕋᕐᐱᐅᑉ ᐃᓗᓯᖓ ᐊᓯᑦᔨᑎᓪᓗᒍ?
- He/she has health issues that require regular medical follow-ups or medication intake on a regular basis. | ᐃᓗᓯᕐᓗᓂᒃᑯᑦ ᐱᑐᓗᑦᑲᕐᐸᑦ ᑲᒥᔭᐅᒥᐊᕐᑲᕐᑲᑦᑕᓚᕐᑭᑦᓯᓂ ᕐᑲᐅᑕᓖᖅ ᐋᓐᓂᐊᓯᐅᕐᑎᓄ ᐄᕐᑲᓇᐊᕐᑲᓚᕐᑭᑦᓯᓂᓪᓘᓐᓃᑦ.

If YES, explain | ᐊᖏᕈᕕᑦ, ᑐᑭᓯᑎᑦᓯᒥᑦ: ______________________________

2. Has your child ever had an allergic reaction after receiving a vaccine or other product?
ᐱᐊᕈᑦ ᕿᓄᓚᕐᓯᒪᕙ ᑲᐱᔭᐅᓈᕋᒥ ᐊᓯᖏᓐᓂᓘᓐᓃᑦ ᕿᓄᓚᕈᑕᐅᔫᓂᒃᕙ?

OUI | ᐋᐊ **NON** | ᐊᐅᑲ **NE SAIS PAS** | ᕐᑲᐅᔨᒪᖕᖏᑐᖓ

If YES, explain | ᐊᖏᕈᕕᑦ, ᑐᑭᓯᑎᑦᓯᒥᑦ: ______________________________

3. Does your child have immune-system problems due to a disease (e.g. leukemia) or medication (e.g. chemotherapy)?
ᐱᐊᕈᑦ ᐋᓐᓂᐊᓂᒃ ᑎᒥᖓ ᓴᐴᓗᑌᑭᑦᓯᒪᕙ ᐋᓐᓂᐊᕐᑲᕐᓂᒥᓄᑦ **(ᐅᑦᑑᑎᒋᑦᓱᒍ leukemia)** ᒪᒥᑉᐸᓚᐊᒍᑎᓄᓪᓘᓐᓃᑦ **(ᐅᑦᑑᑎᒋᑦᓱᒍ chemotherapy)?**

OUI | ᐋᐊ **NON** | ᐊᐅᑲ **NE SAIS PAS** | ᕐᑲᐅᔨᒪᖕᖏᑐᖓ

4. Does your child have a blood clotting disorder requiring medical attention or medication?
ᐱᐊᕈᑦ ᐊᐅᓇᑦᓯᑕᔫᖑᕙ ᑲᒪᒋᐊᔭᐅᒥᐊᕐᑫᓇᓯᓂ ᐄᕐᑲᓯᓂᓪᓘᓐᓃᑦ?

OUI | ᐋᐊ **NON** | ᐊᐅᑲ **NE SAIS PAS** | ᕐᑲᐅᔨᒪᖕᖏᑐᖓ

5. Do either of these situation apply to your child?
ᐅᑯᐊ ᐱᑦᔪᑏᑦ ᕿᑐᕐᖓᓄᑦ ᐊᑑᑎᕐᑲᕐᐸᑦ?

OUI | ᐋᐊ **NON** | ᐊᐅᑲ **NE SAIS PAS** | ᕐᑲᐅᔨᒪᖕᖏᑐᖓ

- He/She have received a vaccine in the past 14 days.
ᑲᐱᔭᐅᓚᐅᕋᑕᕈᓇᑦᓱᑐᖅ ᐅᓪᓗᐃᑦ ᖅᑲ (ᕿᓚᓪᓗ ᓯᑕᒪᓂᓪᓗ0 ᓈᓯᒪᓕᕐᑎᓗᒥᑦᕙ)

SECTION C– CONSENT | ᐊᕕᑦᑐᓯᒪᓂᖓ ᑕ– ᐊᖏᕈᑎᒃ

As the parent or guardian of a child under 14 years, you are responsible for decisions concerning vaccination for that child as well as the transmission of personal information concerning him or her. | ᐊᖓᔪᖅᑳᕆᔭᐅᒍᕕᑦ ᑲᒪᔨᒥᔭᐅᒍᕕᒡ ᓄᑖᑦ ᑲᒃᑲᓛᒥᒃ 14 ᒥᑦᓯᑎᒍᑦ ᐅᑭᐅᓚᒻᒥᒃ, ᑐᑮᖅᑎᐅᒥᐊᖅᑲᖃᔭᖅᐳᑎᑦ ᑲᐱᔭᐅᒍᑎᑦᓴᖏᓐᓂᒃ ᑐᑭᓯᒪᐅᑎᑦᓴᖏᓐᓂᓗ ᑐᓴᐅᒪᑎᑦᓯᓂᕐᒥᒃ ᑲᒪᒥᐊᖅᑲᖃᔭᓇᕗᑎᑦ.

Explanations to help you make an informed decision are provided in the booklet attached to this form. If you would like additional information about vaccination programs, please contact your local CLSC or speak with the school nurse. | ᑐᑭᓯᒪᐅᑎᑦᓴᑦ ᑐᑭᑖᕈᑎᑦᓴᑎᑦ ᐊᑐᐊᒫᐱᓐᓂᒃ ᐊᓪᓚᓯᒪᔪᑦ ᐃᓚᒥᔭᐅᔪᑦ ᑖᑦᓯᒥᖓ ᐊᓪᓚᕕᑦᓴᒥᒃ, ᑐᑭᓯᒥᐊᓪᓚᕈᒪᒍᕕᑦ ᑲᐱᔭᐅᓂᐅᑉ ᒥᑦᓵᓄᑦ ᐊᐱᕐᓱᓗᑎᑦ ᐋᓐᓂᐊᕕᐊᐱᓯᓐᓂ ᐅᕝᕙ ᓘᓐᓃᑦ ᐅᖄᕕᖅᑲᖅᓗᑎᑦ ᐃᓕᓴᕐᕕᐅᑉ ᐋᓐᓂᐊᓯᐅᖅᑎᖓᓄᑦ.

By giving your consent, you agree to the full vaccination serie. | ᐊᖏᕐᓂᓄᑦ, ᐊᖏᕈᑎᖅᑲᖅᑯᑎᑦ ᑲᐱᔭᐅᓐᓂᖓᓂᒃ ᐃᓘᓐᓇᖏᓐᓂᒃ.

If your child has already had positive test to COVID-19, the vaccinator will assess him/her and then administer the required number of doses. | ᐱᐊᕗᑦ ᖃᐅᔨᓴᖅᑕᐅᓛᖅᑐᕕᓂᐅᑉᐸᑦ ᖃᐅᔨᓴᖅᑕᐅᒍᑎᖓ ᓄᓇᕙᓇᖅ-19ᖃᕐᓂᕗᑉᐸᑦ, ᑲᐱᓐᓂᔫᖅ ᖃᐅᔨᒥᐊᓛᖅᑐᖅ ᑲᐱᓯᓛᖅᓯᓂᓪᓗ ᖃᑦᓯᕕᓪᓗᓂ ᑲᐱᔭᐅᒥᐊᖃᕐᓂᖓᓄᑦ.

Do you agree or refuse to allow your child to get the mRNA vaccine against COVID-19 (Pfizer for children aged 12 to 13 years old or Pfizer pediatric for children 5 to 11 years old)? | ᐊᖏᕐᐱᑦ ᐊᖏᖖᒋᓚᑎᒡ ᓄᑖᑦ ᐱᐊᕗᑦ ᑲᐱᔭᐅᓂᖓᓄᑦ L$ᓇᒍ-ᒧᑦ ᑲᐱᔭᐅᒥᐊᓪᓚᓂᑦᓴᖓᓄᓪᓗ ᓄᕙᓇᖅ-ᖅᓪ ᒧᑦ 9ᖃᑯᓂᖓᕿᑭ-ᒧᑦ ᐱᐊᕗᑦ ᐅᑭᐅᓘᑦ ᖅᐸ-ᓂᒃ ᖅᕿ-ᒧᑦ ᐅᕝᕙ ᓘᓐᓃᑦ ᖃᑯᓂᖓᕿᑭ ᕌᕿᑯᓂᖏᑎᑭᓂᖃ ᐱᐊᖃᕿᓄᑦ ᐅᑭᐅᓪᓗᓄᑦ ᑦ-ᓂᒃ ᖅᖅ-ᒧᑦ0

I AGREE | ᐊᖏᕐᐳᖓ **I REFUSE** | ᐊᖏᖖᒋᓚᖓ

☐ I wish my child to be vaccinated DURING SCHOOL VACCINATION | ᐱᐊᖃᖃᓂᒃ ᑲᐱᔭᐅᖅᑯᕌᕗᖓ ᐃᓕᓴᕐᕕᒥ ᑲᐱᔭᐅᓯᑐᐊᕐᐸᑕ

☐ I prefer to get my child vaccinated at the CLSC or during another vaccination event (he will not get his vaccine at school) | ᐱᐊᖃᖃᓂᒃ ᑲᐱᔭᐅᖖᒌᖅᑯᕌᕗᖓ ᐋᓐᓂᐊᕕᒻᒥ ᐅᕝᕙ ᓘᓐᓃᑦ ᐊᓯᐊᓂ ᑲᐱᔭᐅᓯᑉᐸᑕ (ᑲᐱᔭᐅᓛᖖᒋᑐᖅ ᐃᓕᓴᕐᕕᒥ)

Signature of Mother, Father of Guardian | ᐊᑎᓕᐅᕐᕕᖓ ᐊᓈᓇᖓ ᑲᒪᔨᒥᔭᐅᔫᓐᓄᑦ ______________________

Relationship (Mother, Father or Guardian) | ᑭᓇᒥᔭᐅᓂᖓ (ᐊᓈᓇᖓ ᐊᑖᑕᖓ ᑲᒪᔨᒥᔭᐅᔫᓐᓄᑦ) ______________________

DATE | ᐅᓪᓗᒌᖓ: : ______________ | ______________ | ______________

YYYY | ᐊᐊᐊᐊ MM | ᑕᑕ DD | ᐅᐅ