



MOCLI60792

Installation : _____

Dossier : _____

Nom, prénom : _____

Date de naissance : _____ ☐ F ☐ M
aaaa/mm/jj

NAM : _____ Exp. _____
aaaa/mm

Nom, prénom de la mère : _____

THIRD-PARTY CONSENT TO THE VACCINATION OF AN ADULT USER INCAPABLE OF GIVING CONSENT

I, the undersigned: _____ Name in block letters

In my capacity as: ☐ Representative ☐ Tutor ☐ Spouse ☐ Relative ☐ Person with an interest

Authorize: The health professionals authorized by Santé Québec

To: Administer, to the person identified on this form, the vaccines covered by the Ministère de la Santé et des Services sociaux (MSSS) du Québec. This authorization **covers the annual flu (influenza) and/or COVID-19 vaccination** and all **booster doses recommended** in the Protocole d'immunisation du Québec (PIQ; Québec immunization schedule), based on age, medical conditions, living environment, and at-risk contacts. **It also includes any other vaccine offered free of charge** as part of the vaccination program covered by the MSSS.

For the period This consent is valid for the duration of the user's stay at: _____ location

OR until (date): _____ yyyy/mm/dd, unless I withdraw my consent in writing or by phone, in the presence of a witness.

VACCINES COVERED BY THE MSSS

Vaccine	Information sheet given	
COVID-19:	I authorize the vaccine <u>initials</u> I refuse the vaccine <u>initials</u>	<u>Professional's initials</u>
Flu (influenza):	I authorize the vaccine <u>initials</u> I refuse the vaccine <u>initials</u>	<u>Professional's initials</u>
Respiratory syncytial virus (RSV):	I authorize the vaccine <u>initials</u> I refuse the vaccine <u>initials</u>	<u>Professional's initials</u>
Pneumococcus:	I authorize the vaccine <u>initials</u> I refuse the vaccine <u>initials</u>	<u>Professional's initials</u>
Shingles:	I authorize the vaccine <u>initials</u> I refuse the vaccine <u>initials</u>	<u>Professional's initials</u>
Other:	I authorize the vaccine <u>initials</u> I refuse the vaccine <u>initials</u>	<u>Professional's initials</u>

As part of a discussion between you and an authorized professional,* you will be asked annually or as needed to:

- **Reconfirm** your consent to the vaccines for the coming year

OR

- **Revoke** this consent if you no longer want the incapable person to be vaccinated

Your consent or refusal will be recorded in their medical record. This process is part of the preparations for the annual vaccination campaign. Rest assured that even with your consent, **we will always respect the person's wishes**. If they categorically refuse, we will not administer the vaccine, and you will be contacted.

Signature and title of the authorized professional:* _____ Date: _____ yyyy/mm/dd

* Authorized professional: doctor, midwife, nurse, respiratory therapist, pharmacist.

SUBSTITUTE CONSENT

I have been informed of the benefits and risks of accepting or refusing the recommended vaccinations. I was given the opportunity to ask all my questions, and I received satisfactory answers. I know that I may withdraw my consent at any time. This information allows me to make a voluntary and informed decision.

I understand that the incapable person may refuse to be vaccinated on the day of the vaccination, and that their refusal will be respected despite my consent.

Signature of authorized person: _____ Date: _____ yyyy/mm/dd

Phone number: _____

THIRD PARTY'S VOLUNTARY AND INFORMED CONSENT

Relationship with user: ☐ Representative ☐ Tutor ☐ Spouse (married, civil union, or de facto spouse)
☐ Close relative of the incapable adult
☐ Person with a specific interest in the incapable adult

 Last name and first name of authorized person

 Phone number

 Signature of authorized person

 Date (yyyy/mm/dd)

Authorized person's mailing address or email: _____

THIRD PARTY'S VOLUNTARY AND INFORMED CONSENT - BY PHONE

After providing the above information, I received voluntary and informed consent by phone from:

 Last name and first name of authorized person

 Relationship to user

 Phone number

 Signature and title

 Date (yyyy/mm/dd)

 Signature and title of witness to the voluntary and informed consent by phone

Authorized person's mailing address or email: _____

WITHDRAWAL OF CONSENT

After receiving the necessary explanations and information about the diseases and their respective vaccinations, I wish to withdraw my consent to vaccination, on behalf of the person whom I legally represent.

The withdrawal of consent applies to the following vaccination(s):

☐ Flu (Influenza)

☐ COVID-19

☐ RSV

☐ Shingles

☐ Pneumococcus

Relationship with user: ☐ Representative ☐ Tutor ☐ Spouse (married, civil union, or de facto spouse)
☐ Close relative of the incapable adult
☐ Person with a specific interest in the incapable adult

 Last name and first name of authorized person

 Phone number

 Signature of authorized person

 Date (yyyy/mm/dd)

WITHDRAWAL OF CONSENT BY PHONE

After providing the above information, I received withdrawal of consent by phone from:

 Last name and first name of authorized person

 Relationship to user

 Phone number

 Signature and title

 Date (yyyy/mm/dd)

 Signature and title of the witness to the withdrawal of consent by phone