CONSENT FORM

Pre-Departure Medical Services of the Interim Federal Health Program, Immigration Refugees and Citizenship Canada

To be read and signed by all refugees overseas who are beneficiaries of the Interim Federal Health Program and undergo IMEs and/or receive vaccinations through the International Organization for Migration

A. In connection with the Immigration Medial Examination (IME) required for my immigration to Canada and paid for by the Interim Federal Health Program (IFHP), I hereby agree as follows:

1. I understand that IME is part of the resettlement process as required by Immigration Refugees and Citizenship Canada (IRCC). I understand that I have the right to refuse IME but accept that such refusal will have a negative impact on my application for immigration to Canada.
2. I understand that the International Organization for Migration (IOM) Medical Team may request me to undergo other examinations, certain medical tests, or treatment in order to complete the health assessment and/or to comply with the requirements of *Immigration and Refugee Protection Act* of Canada. For each of these requests, I understand that I will be presented with the medical admissibility implications, as well as consequences if I opt not to undergo specific examination, test or treatment.
3. I understand the importance of disclosing to the IOM medical team full and truthful information about my health, to the best of my awareness, in particular if I am pregnant, or if I am uncertain about my pregnancy status.
4. I authorize IOM medical personnel to perform IME and authorize IOM, its employees, medical personnel or its representative(s) to release IME results or records to Immigration Refugees and Citizenship Canada and Medavie Blue Cross for the administration of the Interim Federal Health Program. The IME includes, but is not limited to, a full physical examination, a questionnaire related to my past and current health condition(s), a chest x-ray, HIV and Syphilis blood tests, and a urine test.
5. If the results of this IME indicate that I have a medical condition related to a danger to public health, I understand that a condition of my admissibility to Canada may be a requirement to report to a provincial/territorial or local public health authority for a medical follow-up (medical surveillance) upon my arrival in Canada.
6. I understand that the by law all medical providers are obliged to report certain medical conditions to local authorities.

☐ I agree ☐ I do not agree

B. In connection with vaccination(s) offered by the IOM and paid for by the Interim Federal Health Program, I hereby agree as follows:

1. I give my permission to receive vaccine(s) for myself or my dependents and confirm that I have read the contents of the Vaccine Information Statements for the vaccines that has been given to me or my dependents and/or that it has been explained to me.
2. I acknowledge that I had the opportunity to ask questions and I confirm that I understand the benefits and risks of vaccine(s) offered to me and my dependents.
3. I understand that, according to the laws in Canada, I may refuse any vaccine based on my opposition to vaccination in any form, and that my refusal will not affect my eligibility for resettlement to Canada.
4. I authorize IOM, its employees, medical personnel or its representative(s) to administer vaccination(s) to me or my dependents
5. I authorize IOM, its employees, medical personnel or its representative(s) to release vaccination records to Immigration Refugees and Citizenship Canada and Medavie Blue Cross for the administration of the Interim Federal Health Program.

☐ I agree ☐ I do not agree

Client's name:_____Signature: _____date_____
mm-dd-yyyy

Guardian's name _ *If client is under 16 y.o.* _____Signature:_____ date_____
mm-dd-yyyy

Counsellor's name_____ Signature: _____date_____
mm-dd-yyyy