

COVID-19 vaccination **consent form**

Person

Surname _____ First name _____

Phone _____ Date of birth ___ / ___ / ___ Age ____ years

Address _____

Medical Centre/GP _____ NHI _____

Please let the vaccinator know:

- If you are unwell
- If you are pregnant or breastfeeding
- If you're on blood-thinning medications or have a bleeding disorder
- If you've had a previous severe allergic reaction to any vaccine or injection in the past

If you are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years you will get the paediatric dose
- If you have had myocarditis or pericarditis after a vaccination in the past

If you are receiving Novavax, please let your vaccinator know:

- If you are aged under 18 years

If you are receiving AstraZeneca, please let your vaccinator know:

- If you are aged under 18 years
- If you've ever had a major clot or low blood platelets in the past, or have an autoimmune condition that means you are more likely to have a clot
- If you've ever had capillary leak syndrome, a rare condition causing fluid leakage from small blood vessels

- I have read the COVID-19 information provided, and/or have had explained to me information about the COVID-19 vaccine.
- I have had a chance to ask questions and they were answered to my satisfaction.
- I understand the benefits and risks of COVID-19 vaccination.
- I understand I will need 2 doses of the COVID-19 vaccine to be fully vaccinated.
- I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.
- I understand the side effects associated with this vaccine and know how to get help if needed.

Signature _____ Date ___ / ___ / ___

Parent / legal guardian / enduring power of attorney

I am the parent, legal guardian or enduring power of attorney, and agree to the COVID-19 vaccination of the person named above.

Name of parent or legal guardian _____ Phone _____

Relationship to person being vaccinated _____

Signature _____ Date ___ / ___ / ___

Tick the vaccine dose that applies:

Paediatric Pfizer	Dose 1 5-12 years <input type="checkbox"/>	Dose 2 5-12 years <input type="checkbox"/>		
Pfizer	Dose 1 12 years and above <input type="checkbox"/>	Dose 2 12 years and above <input type="checkbox"/>	Dose 3* 12 years and above <input type="checkbox"/>	Booster 18 years and above <input type="checkbox"/>
AstraZeneca	Dose 1 18 years and above <input type="checkbox"/>	Dose 2** 18 years and above <input type="checkbox"/>	Dose 3* 18 years and above <input type="checkbox"/>	Booster* 18 years and above <input type="checkbox"/>
Novavax	Dose 1 18 years and above <input type="checkbox"/>	Dose 2** 18 years and above <input type="checkbox"/>		

I understand that I am receiving a vaccine as indicated above and understand the information given to me. I agree to receive the vaccine indicated above.

Signature _____ Date ___ / ___ / ___

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label. For any off-label use of a vaccine a prescription is required.

Authorised prescriber (incl. medical practitioner, nurse practitioner or pharmacy prescriber)

I confirm that I have explained the reasons for, the risks and outcomes of the **Pfizer, AstraZeneca or Novavax** vaccination to the person named on this consent form.

(please circle one above)

Name _____ APC number _____

Signature _____ Date ____ / ____ / ____

For prescription requirements please see the relevant Policy Statement.

Information for Vaccinator

Details confirmed Positive answer to any screening questions? Yes No

Record information and advice given:

Informed consent obtained? Yes No Date ____ / ____ / ____ Time _____

Vaccine							Diluent		
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Pfizer only		
							Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
AstraZeneca			0.5mL						
Novavax			0.5mL						

Paediatric Pfizer	Dose 1 5-12 years <input type="checkbox"/>	Dose 2 5-12 years <input type="checkbox"/>				
Pfizer	Dose 1 12 years and above <input type="checkbox"/>	Dose 2 12 years and above <input type="checkbox"/>	Dose 3* 12 years and above <input type="checkbox"/>	Booster 18 years and above <input type="checkbox"/>		
AstraZeneca	Dose 1 18 years and above <input type="checkbox"/>	Dose 2** 18 years and above <input type="checkbox"/>	Dose 3* 18 years and above <input type="checkbox"/>	Booster* 18 years and above <input type="checkbox"/>		
Novavax	Dose 1 18 years and above <input type="checkbox"/>	Dose 2** 18 years and above <input type="checkbox"/>				

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label.

Vaccinator information Name _____ Signature _____ Post vaccination information given <input type="checkbox"/>	Observation area information Details of any AEFI or observations recorded <input type="checkbox"/> CARM Report completed <input type="checkbox"/> Signature _____ Departure time _____
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Vaccination site clinical lead
If administering an off-label use, this should be signed below by the clinical lead.

Name _____
Signature _____ Date ____ / ____ / ____

When a prescription is used, the prescriber must retain this form or a copy, and hold securely as a medical record in accordance with local policy.