COVID-19 vaccination **consent form**

Person

Surname _____ First name _____

Phone _____ Date of birth ___ / ___ / _____ Age _____ years
DD MM YYYY

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 ___ / ___ / _____
DD MM YYYY

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 ___ / ___ / _____
DD MM YYYY

Tick the vaccine dose that applies:

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2 ☐ For those eligible 16 years and above
AstraZeneca	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Dose 3* ☐ 18 years and above	Booster* ☐ 18 years and above	
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Booster ☐ 18 years and above	Booster 2 ☐ For those eligible 18 years and above	

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 ___ / ___ / _____
DD MM YYYY

* 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 benefits of the **Pfizer**, **AstraZeneca** or **Novavax** vaccination to the person named on this consent form.

(please circle one above)

Name _____ APC number _____

Signature _____ Date ___ / ___ / _____ (DD / MM / YYYY)

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 ___ / ___ / _____ (DD / MM / YYYY) Time _____

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

Paediatric Pfizer	**Dose 1** 5-11 years ☐	**Dose 2** 5-11 years ☐	**Dose 3*** 5-11 years ☐		
Pfizer	**Dose 1** 12 years and above ☐	**Dose 2** 12 years and above ☐	**Dose 3*** 12 years and above ☐	**Booster 1** 16 years and above ☐	**Booster 2** For those eligible 16 years and above ☐
AstraZeneca	**Dose 1** 18 years and above ☐	**Dose 2**** 18 years and above ☐	**Dose 3*** 18 years and above ☐	**Booster*** 18 years and above ☐	
Novavax	**Dose 1** 18 years and above ☐	**Dose 2**** 18 years and above ☐	**Booster** 18 years and above ☐	**Booster 2** For those eligible 18 years and above ☐	

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Vaccinator information

Name _____

Signature _____

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature _____

Departure time _____

Vaccination site clinical lead

When administering an off-label dose of vaccine, the clinical lead signs as an informed consent final check with the consumer.

Name _____

Signature _____ Date ___ / ___ / _____ (DD / MM / YYYY)

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.