

# 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
- 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 AstraZeneca, please let your vaccinator know:

- If you are aged under 18 years
- If you are pregnant
- 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 believe 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 \_\_\_\_\_

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"/>

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

Signature \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_

\* These doses are considered off-label use.

\*\* AstraZeneca as a second primary dose following a non-AstraZeneca dose is considered off-label use.

**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** or **AstraZeneca** vaccination to the person named on this consent form. (please circle one)

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PLEASE NOTE:** A prescription from an authorised prescriber is required for a third primary dose of Pfizer. A prescription is recommended for AstraZeneca as a booster dose or a second primary (ie. following a non-AstraZeneca vaccine for dose 1).

**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 <span style="float: right;">Pfizer only</span>		
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						

<b>Paediatric Pfizer</b>	Dose 1 5-12 years <input type="checkbox"/>	Dose 2 5-12 years <input type="checkbox"/>			
<b>Pfizer</b>	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"/>	
<b>AstraZeneca</b>	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"/>	

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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**

If administering an off-label use, such as a third primary dose, AstraZeneca vaccine as a booster dose OR AstraZeneca as the secondary dose of the primary course (ie following non-AstraZeneca COVID-19 vaccine for dose 1), 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.