

COVID-19 vaccination consent form

Patient

Surname _____ First name _____

Phone _____ Date of birth ____ / ____ / ____ NHI _____

Address _____

Medical Centre/GP _____

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
- 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'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 been informed of the contraindications of 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 it is my choice to get the COVID-19 vaccination.

I understand I will need 2 doses of the COVID-19 vaccine to be fully vaccinated.

Signature _____

Date ____ / ____ / ____

Parent / guardian / enduring power of attorney

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

Name of parent or guardian _____

Relationship to patient _____

Signature _____

Date ____ / ____ / ____

Tick the vaccine dose that applies:

Pfizer

Dose 1 Dose 2 Dose 3* Booster

AstraZeneca

Dose 1 Dose 2** Dose 3* Booster*

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.

Medical practitioner

I confirm that I have explained the reasons for, the risks and outcomes of the **Pfizer** or **AstraZeneca** vaccination to the patient named on this consent form. (please circle one)

Signature _____ Date ____ / ____ / ____

PLEASE NOTE: A prescription from a medical practitioner 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 _____

If deferred, declined or not medically fit for vaccine, record detail:

Vaccine							Diluent Pfizer only		
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Pfizer/BioNTech COVID-19 Vaccine			0.3mL						
AstraZeneca			0.5mL						

Pfizer

Dose 1 Dose 2 Dose 3* Booster

AstraZeneca

Dose 1 Dose 2** Dose 3* Booster*

*These doses are considered off-label use.

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

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.