COVID-19 vaccination **consent form**

Person

Surname ______________________ First name ______________________

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

Address ____

Medical Centre/GP ______________________________ NHI ____________

Please let the vaccinator know:

- If you have had myocarditis or pericarditis after a vaccination in the past
- If you are unwell
- 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 are receiving Novavax, please let your vaccinator know:

- If you are aged under 18 years

- ☐ 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
Novavax	Dose 1 ☐ 12 years and above	Dose 2** ☐ 12 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.**

HP7565 | 8 September 2022

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** 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						
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
Novavax	Dose 1 ☐ 12 years and above	Dose 2** ☐ 12 years and above	Booster ☐ 18 years and above	Booster 2 ☐ For those eligible 18 years and above	

* 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 ☐

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.