Tetanus, diphtheria and whooping cough **vaccination consent form**

Person

Surname ______________________ First name ______________________

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

Address ____

Medical Centre/GP ______________________ NHI ______________
National Health Index number if known

Ethnicity (please tick one or more)

☐ NZ European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean ☐ Chinese

☐ Indian ☐ Other – please state ______________________

Consent statements

- ☐ I have read the fact sheet called 'What you need to know about the tetanus, diphtheria and whooping cough vaccination'.
- ☐ The benefits and risks of the Boostrix vaccine have been explained to me and I have been told how long I will need to wait after the vaccination.
- ☐ I had enough time to ask questions and my questions were answered to my satisfaction.
- ☐ I have received or photographed the fact sheet so I can refer to it after I leave the appointment. 'What you need to know about the tetanus, diphtheria and whooping cough vaccination'.
- ☐ I was told how and when to seek assistance if I/ the person being vaccinated experience symptoms that may be vaccine related.
- ☐ The vaccinator has discussed with me other vaccines that I am eligible for.
- ☐ I understand this vaccination information will be recorded and shared with my/the vaccinated person's regular healthcare provider.
- ☐ **I consent to the Boostrix vaccination being given.**

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

As parent / legal guardian / enduring power of attorney

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

Relationship to the person being vaccinated ______________________ Phone ______________

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

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Vaccination record (for vaccinator use)

Consumer details confirmed ☐ Affirmative answer to any screening questions? ☐ Yes ☐ No

If yes, record the detail and advice given ______________________________

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Verbal and written post vaccination information given ☐ Other vaccines discussed ☐

Informed consent obtained? ☐ Yes ☐ No

Is this a funded vaccine? ☐ Yes ☐ No

Indication *(eg pregnant or over 65)* ______________________________

Vaccine details

Name of vaccine	Batch	Expiry	Dose	Needle size	Site	Date	Time
Boostrix			0.5mL				

Vaccinator information

Place of vaccination ______________________________

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Name ______________________________

Signature ______________________________

Clinical supervisor*

Name ______________________________

Signature ______________________________

*if relevant

Observation period information

☐ Details of any AEFI or observations recorded

☐ CARM report completed

Signature ______________________________

Departure time ______________________________

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