Immunisation during pregnancy **consent form**

Person

Surname _____ First name _____

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

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 immunisation during pregnancy'.
- ☐ If receiving a COVID-19 vaccine today, I confirm that I/ the person being vaccinated have not tested positive for COVID-19 in the last 6 months.
- ☐ I understand I will need to wait up to 20 minutes after the vaccination.
- ☐ The benefits and risks of the vaccines I am receiving today have been explained to me.
- ☐ The common and rare side effects of the vaccines I am receiving today have been explained to me.
- ☐ I had enough time to ask questions and my questions were answered to my satisfaction.
- ☐ I have received or photographed these fact sheets so I can refer to them after I leave the appointment.
  - 'What you need to know about immunisation during pregnancy'.
  - 'After your immunisations during pregnancy'.
- ☐ I have been told how and when to seek assistance if I/ the person being vaccinated experience symptoms that may be vaccine related.
- ☐ I understand this vaccination information will be recorded and shared with my/the vaccinated person's regular healthcare provider.
- ☐ **I consent to the following vaccines today** ☐ **Boostrix** ☐ **Flu** ☐ **COVID-19**

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 vaccinations listed above.

Relationship to 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 _____

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

Informed consent obtained? ☐ Yes ☐ No

☐ CIR checked to ensure recommended dose interval before administration of COVID-19 vaccine.

☐ If the consumer is aged 16 to 29 years and receiving an additional COVID-19 vaccine, I have checked that they meet the recommended eligibility for pregnant people at risk with comorbidities.

☐ If the COVID-19 vaccine dose is being administered off label or off Programme recommendations, a prescription has been supplied by an authorised prescriber and will be uploaded to the CIR.

☐ If the Boostrix vaccine is being administered, I have confirmed the consumer is at least 13-weeks pregnant.

Tetanus, diphtheria and whooping cough details

Name of vaccine	Batch	Expiry	Dose	Site	Needle size	Date	Time
Boostrix			0.5mL	Deltoid ☐ L ☐ R			

Flu vaccination details

Name of vaccine	Batch	Expiry	Dose	Site	Needle size	Date	Time
(write vaccine name or place vaccine sticker here)				Deltoid ☐ L ☐ R			

COVID-19 vaccination details

Name of vaccine	Batch	Expiry	Dose	Site	Date	Time
Pfizer Comirnaty COVID-19 vaccine			0.3mL	Deltoid ☐ L ☐ R		

Date of last COVID-19 vaccine ___/___/_____

Additional comments

Vaccinator information

Place of vaccination _____

_____

Name _____

Signature _____

Observation period

☐ Details of any AEFI or observations recorded

☐ CARM report completed

Signature _____

Departure time _____

Clinical supervisor*

Name _____

Signature _____

* if relevant

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