COVID-19 vaccination **consent form**

Patient

Surname ..... First name .....

Phone ..... Date of birth ..... / ..... / ..... NHI .....

Address .....

Medical Centre/GP .....

Support person / guardian / enduring power of attorney

Name (if applicable) .....

Relationship to patient .....

Please let the vaccinator know:

- If you are unwell
- If you've had a previous severe allergic reaction to any vaccine or injection in the past
- If you're on blood-thinning medications or have a bleeding disorder
- If you've had any vaccines in the past four weeks
- If you are pregnant or breastfeeding
- If you are currently receiving the cancer drugs Keytruda, Opdivo, Yervoy, or Tecentriq or have done so in the past six months

I have read the COVID-19 information pamphlet on "What to Expect", 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 it is my choice to get the COVID-19 vaccination.

Signature ..... **Date** ..... / ..... / .....

I am the patient's support person, guardian, or enduring power of attorney, and agree to the COVID-19 vaccination of the patient named above

Signature ..... **Date** ..... / ..... / .....

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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 medical fit for vaccine record detail .....

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Vaccine							**Diluent**		
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Pfizer/BioNTech COVID-19 Vaccine			0.3ml						

Dose 1 ☐ Dose 2 ☐

Post vaccination information given ☐

Signature of vaccinator .....

Name of vaccinator .....

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature .....

Departure time .....

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