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 of guardian (if applicable) _____

Guardian's 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 are pregnant

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 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 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 _____

_____

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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