

16-17 COVID-19 Vaccination Recipient Consent Form & Record

(BLOCK CAPITALS PLEASE)

Pfizer (Cominarty) 16 to 17 years (White)	BOOKED		WALK IN		ARRIVAL TIME:	ZONE NO:	BOOTH NO:
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SURNAME					FORENAME		
DATE OF BIRTH					NHS NUMBER		
1 st LINE OF ADDRESS					POSTCODE		
ETHNICITY (Please tick one)	White	Asian/Asian British	Arabian	Black/African/Caribbean/Black British			
	Mixed	Mixed/multiple ethnic groups	Other ethnic group	Prefer not to say			
Please indicate if this is:	First Covid Vaccine?	Yes	No	Allergies:			
	Date administered:						
	Second Covid Vaccine?	Yes	No				
	Date administered:						

Please read the COVID information leaflet you have been given before proceeding to the Pre-vaccination screening

Pre-vaccination Screening		Circle		If you answer YES to any questions:
1.	Are you currently unwell with a fever?	Y	N	
2.	Have you tested positive for COVID-19 within the past 12 weeks? (unless C.E.V then 28 days)	Y	N	
3.	Are you pregnant?	Y	N	
4.	Have you had a previous systemic allergic reactions (including immediate onset anaphylaxis) to a previous dose of COVID-19 mRNA Vaccine BNT162b2 or COVID-19 Vaccine AstraZeneca, (ChAdOx1-S [recombinant]) or to any component of the vaccine or residues from the manufacturing process?	Y	N	
5.	Have you ever had a history of immediate-onset anaphylaxis to multiple classes of drugs or unexplained anaphylaxis? If yes to Q4 or Q5 assessor to complete reaction section on reverse.	Y	N	
6.	Do you have a bleeding disorder e.g. haemophilia?	Y	N	
7.	Do you have a history of heparin-induced thrombocytopenia and thrombosis (HITT or HIT type 2)?	Y	N	
8.	Have you experienced major venous and/or arterial thrombosis occurring with thrombocytopenia following vaccination with any COVID-19 vaccine?	Y	N	
9.	Are you taking any blood thinning medication e.g. Warfarin? – go to Q.10	Y	N	
10.	If yes, is your INR above the upper threshold for your condition?	N/A	Y	

Please tick the relevant boxes and sign and date below:

BOX A: I have read the information sheet and consent to receiving the COVID 19 vaccination. I am aware that the National Immunisation Vaccination (NIV) service / PharmOutcomes system and other Healthcare providers will be informed I have been vaccinated.

OR
BOX B: I have read the information sheet and following the pre-vaccination screening I am NOT eligible for vaccination.

BOX C: Advice for the public: Vaccinated individuals should be advised to seek immediate medical attention should they experience **new onset of chest pain, shortness of breath, or symptoms of disturbance of cardiac rhythm**. The COVID-19 vaccines remain highly effective in protecting people from COVID-19 and have already saved thousands of lives. These events are extremely rare and tend to be mild when they do occur. Our advice remains that the benefits of getting vaccinated outweigh the risks in the majority of people. It is still vitally important that people come forward for their first and second vaccination when invited to do so, unless advised otherwise. I have been informed and received an information leaflet produced by Public Health England – Covid-19 vaccination and blood clotting information about your vaccination.

SIGNATURE (Patient or parent)		PATIENT CONSENT YES/NO	PARENTAL CONSENT YES/NO
<i>If Child lacks capacity parental consent can be given</i>			
PRINT NAME (Patient or parent)		RELATIONSHIP TO PATIENT	DATE
REGISTRANT TAKING CONSENT	PRINT NAME:	Signature:	
CLINICAL SUPERVISOR			

