<u>16-17 COVID-19 Vaccination Recipient Consent Form & Record</u> (BLOCK CAPITALS PLEASE)



Saddlers Mass Vaccination Centre

Pfizer (Cominarty) 16 to 17 years (White)		17	BOOKED WALK IN				ARRIVAL TIM		ME:	ZONE	NO:	воотн	10 :			
SURNAME										FOR	RENAME					
DATE OF BIR	тн									NHS	S MBER					
1st LINE OF ADDRESS										•		POS	STCODE			
ETHNICITY		White Asian/Asian British					Arabian						Black/Afr British	ican/Carib	bean/Black	
(Please tick o	one)	ked		Mixed/multiple ethnic groups			Other ethni		ethnic	ic group			Prefer not to say			+
Please indica	te if Fir	First Covid Vaccine?					Yes	N	lo		Allerg	ies:	ı			
this is:		ate adm														
		cond Co					Yes	N	10							
Please read	I	ate adm D infori			ou have	been give	n bef	ore pro	cee	ding t	o the Pi	re-vacc	ination s	creening	3	
Pre-vaccinati	ion Screeni	ng								Cir	cle	If you a	nswer YES	to any qu	estions:	
	ou currentl									Υ	N	1 D	o not proco	ad with va	th vaccination	
			for CO	OVID-19 with	nin the p	ast 12 week	s? (un	ıless		Υ	N	1. Do not proceed with vaccination				
	then 28 da ou pregnan								+	Υ	N					
			s syste	mic allergic	reaction	ns (including	imme	ediate	+	<u>'</u> Ү	N	Please speak to one of the nurses who advise next steps			5 Will	
onset or CO	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?								In relation to question 2: Previous pos			sitive				
										Υ	N	test for COVID 19 status- delay va				
classe	Have you ever had a history of immediate-onset anaphylaxis to multiple classes of drugs or unexplained anaphylaxis?							ī	until 12 weeks (3 months; Unless C.E.V then 28 days					ve PCF		
						ection on rev	verse.	•	_							
				er e.g. haem		cytopenia ar	d +br	am basis		Y	N N					
(HITT	or HIT type	2)?							•							
						al thrombosis any COVID-1				Υ	N					
9. Are yo	ou taking ai	ny blood	d thinn	ing medicat	ion e.g. \	Warfarin? – g	go to	Q.10		Υ	N	If yes, vaccination still likely to be possible depending on answer to Q.10				
10. If yes,	, is your INF	r INR above the upper threshold for your condition				?	N/A	A	Y N If YES, do not proceed with vaccinati to ask GP for further advice. If NO, co vaccination.							
National I OR BOX B: I h BOX C: Ac pain, shou have alrea vaccinated do so, unl	nave read the Immunisation nave read the dvice for the rtness of bre ady saved the d outweigh t	e informa n Vaccina e informa public: Va ath, or sy ousands o he risks in	ation shotion (Nation shotion shotion shotion shotion accinate ymptor of lives. I have	eet and conse IV) service / P eet and follow ed individuals ns of disturba . These events najority of pec e been inform	ving the particle of the parti	emely rare and still vitally imp	n and on screet eek im The Cod tend	ening I an mediate COVID-19 to be mi	n <u>NO</u> medi vacci ild wh	re prov Feligible fical atte nes ren en they ome fo	iders will le for vaccention shoud highler ward for the will will be seen the will be seen	be inforr cination. ould they ly effection r. Our addition	experience ve in protec vice remain st and secor	e new onsetting peop as that the and vaccina		tting ited to
SIGNAT	URE (Patient	or parer	nt)				PATIE	NT CONSI	ENT	YES	S/NO	PARE	NTAL CONSE	NT YES/N	10	
	If Child lacks capacity parental consent can be given PRINT NAME (Patient or parent)					RELATIONSHIP TO PATIENT				DATE	<u> </u>					
REGIST TAKING	RANT G CONSENT		NT NAM	JE:			Signa	ture:								
CLINICA	AL															

Vaccination details – administered via National protocol for: COVID-19 mRNA vaccine BNT162b2 (Pfizer) version: v02.00 /

Please attach vaccine label – to include vaccine name, amount in mls to be given, batch number and expiry date:

VACCINE ADMINISTERED: YES / NO – check DOB					
	Vaccinator Profession:				
	Vaccinator ID:				
	Vaccinator Name / Stamp:	PLEASE ENTER NAME IN CAPITALS			
	Vaccination Site:	Left upper arm			
		Right upper arm			
	Which Dose:	First dose of vaccine			
		Second dose of vaccine			
	Vaccinator Signature: Date:				
	Time (24 hour):				
	•				

VACCINE ADMINISTERED: NO
NOT VACCINATED? COMMENTS. PLEASE INCLUDE ADVICE GIVEN/PATIENT COMMENTS/REBOOKED DATE? ETC.

Reaction Type	Allergy		Intolerance		
Reaction (Please refer to sheet at data entry desk)		•			
Criticality	High	Low	Unable to assess		
Date First Experienced					
Verification Status	Confirmed		Suspected		

Discuss with Clinical supervisor

OBSERVATIONS POST VACCINE							
Recorded observations for any assistance required for the patient and actions taken							
Date and Time:	Staff name/PIN number						
Comments:							
STAFF SIGNATURE:							