12-15 COVID-19 Vaccination Recipient Consent Form & Record

(BLOCK CAPITALS PLEASE)

Walsall Healthcare NHS
NHS Trust
Saddlers Mass Vaccination Centre

Pfizer (Comirnaty) 12 to 15 years (Purple)	BOOKED		WALK IN		ARRIVAL TIME:	ZONE NO:	BOOTH NO:

SURNAME				FORENAME	
DATE OF BIRTH		Is the child 12 years of age?	Yes / No (Under 12 do not vaccinate)	NHS NUMBER	
1st LINE OF ADDRESS				POSTCODE	

ETHNICITY (Please tick one)	White		Asian/Asian British		Arab		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 Date administered: Second Covid Vaccine? Yes No Date administered:	Known Allergies (please list or write 'none'):

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	1. Do not proceed with vaccination 2. Please speak to one of the nurses who will advise next steps 3. In relation to question 6: Previous positive test for COVID 19 status- delay vaccination until 12 weeks (3 months) from positive PCR or C.E.V 28 days
2.	Have you tested positive for COVID-19 within the past 12 weeks? (if C.E.V within 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	If yes, vaccination still likely to be possible depending on answer to **Q.10**
10.	If yes, is your INR above the upper threshold for your condition?	N/A	Y	N	If YES, do not proceed with vaccination; recipient to ask GP for further advice. If NO, continue with vaccination.

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 (Person with parental responsibility)		PARENTAL CONSENT YES/NO (If no do not vaccinate)	DATE
PRINT NAME (Parent):		RELATIONSHIP TO PATIENT	
REGISTRANT TAKING CONSENT	PRINT NAME:	Signature:	Confirm child is over the age of 12 years – check DOB Please circle Y N If no do not vaccinate
CLINICAL SUPERVISOR			

Vaccination details – administered via National protocol for:
COVID-19 mRNA vaccine BNT162b2 (Pfizer/BioNTech) 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 – vaccinator must confirm that child is 12 years and over – 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.

(Q4 Q5) PREVIOUS ADVERSE REACTIONS TO VACCINE/DRUG *(Please circle)*

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	

SECOND APPOINTMENT

Currently not needed in this age group

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: