**COVID-19 Vaccination consent form  
Please complete all the boxes below in black ink and in capitals**

**The form must be signed by the child’s parents or guardian**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Must be completed –**  **GP practice name and address:** | | | | |
| **Child’s full Name (First name and surname):** | | **Date of birth:** | **Male / Female** | |
| **Home address:** | | **Daytime contact telephone number:** | | |
| **Email address:** | | **NHS Number (if known):** | | |
| **Ethnicity:**  **Religion:** | **School:** | | | **Year Group/Class:** |

|  |  |  |
| --- | --- | --- |
| Has your child had a previous COVID-19 Vaccination? | Yes  Date: | No |
| Does your child have an allergy? | Yes  Please give details: | No |
| Is your child taking any medicines or receiving any medical treatment? | Yes  Please give details: | No |

**Consent for the vaccination** (Please complete one box only)

|  |  |
| --- | --- |
| **I have read and understood the information provided regarding the Covid-19 vaccination** | |
| **Yes** | **No** |
| I **do consent** for my child to receive covid-19 vaccination | I **do not consent** for my child to receive covid-19 vaccination |
| **Signature:**  Parent / Guardian /  Self-consent by young person | **Signature:** |
| **Print name:**  Parent / Guardian /  Self-consent by young person | **Print name:** |
| **Relationship to child:**  If consent not provided  by young person | **Relationship to child:** |
| **Date:** | **Date:** |

**Unsure currently**

**If you are unsure and would like to attend the session on the day to ask further questions and decide on the day**

|  |  |
| --- | --- |
| **Name of child:**  Parent / Guardian /Self-consent by young person | |
| **Relationship to child:**  If consent not provided by young person | |
| **Signature:** Parent /Guardian/ Self-consent by young person | **Date** |

**This section is to be completed on the day by the vaccinator**

**This information is shared with you, so that you are familiar with the questions that will be asked. Some questions may not be relevant**

|  |  |  |
| --- | --- | --- |
| **Name** |  | |
| **Date of birth** |  | |
| **Age** |  | |
| **NHS number** |  | |
| **Appointment date** |  | |
| **Appointment time** |  | |
| **Registered practice** |  | |
| **Invited by** |  | |
| **Ethnicity** |  | |
| **DOSE** |  | |
|  | Social worker  Health care  Worker Care home worker  Lives in care home  None | |
| Are you currently unwell with fever? | | Yes No |
| Have you participated in the covid vaccination trial? | | Yes No |
| Are you under 18 years of age? | | Yes No |
| Have you ever had any serious allergic reactions needing adrenaline? | | Yes No |
| Are you taking a blood thinning medicine like warfarin, aspirin, DOAC? | | Yes No |
| Have you had any vaccinations in the last seven days? | | Yes No |
| Are you waiting for COVID test result or have you had COVID in the last 28 days? | | Yes No |
| Are you currently pregnant or breastfeeding? | | Yes No |

