**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**

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| **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? | YesDate: | No |
| Does your child have an allergy? | YesPlease give details:  | No |
| Is your child taking any medicines or receiving any medical treatment? | YesPlease give details: | No |

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

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| **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**

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| **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 |

