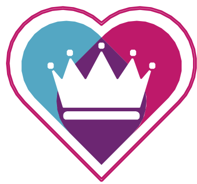

COVID 19

NHS

Vaccination consent form for children and young people

The COVID-19 vaccine is being offered to your child. Your child will receive their first COVID-19 vaccine and you may be notified about the second dose later. The leaflet sent with this form includes more information about the vaccines currently in use. Please discuss the vaccination with your child, then complete this form before it is due. Information about the vaccinations will be put on your child's health records.

Child's full name (first name and surname):	Date of birth:
Home address:	Daytime contact telephone number for parent/carer:
NHS number (if known):	Ethnicity:
School (if relevant):	Year group/class:
GP name and address:	

About your child	Yes	No
Is the child aware they will be receiving the mRNA Covid 19 vaccine?		
Is your child currently fit and well and not showing any symptoms for Covid 19?		
Has your child had a positive PCR test for Covid 19 in the last 4 weeks?		
Has your child had any other vaccines or injections including the Covid 19 vaccine, OR the Nasal Flu Vaccine (LAIV) within the last 7 days? If you are unsure, please contact your GP to confirm.		
Has your child had any previous reactions to any medications or vaccinations? If yes, please provide details:		
Does your child have any medical conditions, or are they receiving any treatment from hospital and/or the GP? If yes, please give details here:		
Does your child have any allergies: if so please specify?		
Has the child had an unexplained anaphylactic reaction?		
Does your child take any medications/tablets/inhalers/prescribed creams? If yes please give details here:		
Does you child take any anticoagulation medication, or do they have a bleeding disorder?		
Has your child been involved in the trial of the Covid vaccine?		
Could your child possibly be pregnant?		

Consent for COVID-19 vaccination (Please complete **one** box only)

I want my child to receive the COVID-19 vaccination	**I do not want** my child to have the COVID-19 vaccine
Signature: Parent/Guardian	Signature: Parent/Guardian
Parents Name:	Parents Name:
Date:	Date:
Tick or cross in the box if you DO want your child to have the vaccination ☐	Tick or cross in the box if you DO NOT want your child to have the vaccination ☐

Screening questions to be completed by the NURSE administering the immunisation.

Are all of the details on the form correct?	Y	N	Do any reasonable adjustments need to be made for the young person?	Y	N
Will the child receive immunisation today?	Y	N	Have you asked all the questions overleaf with the young person	Y	N
If deferred give reasons:					

Name of Young person		DOB	
Individual is excluded or declines vaccination ☐	The risk to the individual of not being immunised must be considered. Where appropriate, such individuals should be referred to a specialist-led clinic for assessment of clinical risk. Document reason for exclusion and action taken		
Individual to be vaccinated ☐	Proceed to administration		

I authorise for the above named individual to receive the following vaccination:

Name of vaccination:	Comirnaty® COVID-19 mRNA Vaccine		
First dose:	☐	**Second dose**	☐
Strength of vaccination:	30 micrograms	**Frequency:**	Single dose to be repeated once, between 4 and12 weeks later *Note the SPC recommends second dose is given 3 weeks after the first. In line with the JCVI recommendation, dose intervals have been extended as there is evidence of better immune response. This is outside the product license.*
Dose:	0.3ml (30 micrograms)	**Route of administration:**	Intramuscular (IM) Injection

Name of Assessing Nurse:		**Signature**		**Date**	

Dose made up by: (insert name)	
Dose drawn up by: (insert name)	

Vaccine Batch Number:		**Vaccine expiry date:**	
Date administered:		**Time of administration:**	
Site of administration:	**Right upper arm** ☐	**Left upper arm** ☐	
Name of vaccine administrator:		**Signature of Vaccine administrator**	