COVID-19 vaccination
2 dose consent form

Patient

Surname ..... First name .....

Phone ..... Date of birth ..... / ..... / ..... NHI .....

Address .....

Medical Centre/GP .....

Support person / guardian / enduring power of attorney

Name (if applicable) .....

Relationship to patient .....

Please let the vaccinator know:

- If you are unwell
- If you've had a previous severe allergic reaction to any vaccine or injection in the past
- If you're on blood-thinning medications or have a bleeding disorder
- If you've had any vaccines in the past four weeks
- If you are pregnant or breastfeeding
- If you are currently receiving the cancer drugs Keytruda, Opdivo, Yervoy, or Tecentriq or have done so in the past six months

I have read the COVID-19 information pamphlet on "What to Expect", and/or have had explained to me information about the COVID-19 vaccine.

I have had a chance to ask questions and they were answered to my satisfaction.

I believe I understand the benefits and risks of COVID-19 vaccination.

I understand it is my choice to get the COVID-19 vaccination.

Signature ..... **Date** ..... / ..... / .....

I am the patient's support person, guardian, or enduring power of attorney, and agree to the **2 doses** of COVID-19 vaccination of the patient named above

Signature ..... **Date** ..... / ..... / .....

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Information for Vaccinator

Details confirmed ☐

Positive answer to any screening questions? Yes ☐ No ☐

Record information and advice given:

Informed consent obtained? Yes ☐ No ☐

Date ..... / ..... / ..... Time .....

If deferred, declined or not medical fit for vaccine record detail .....

.....

Vaccine							Diluent		
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Pfizer/BioNTech COVID-19 Vaccine			0.3ml						

Dose 1 ☐ Dose 2 ☐

Post vaccination information given ☐

Signature of vaccinator .....

Name of vaccinator .....

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature .....

Departure time .....

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