

CONSENT FORM –



COVID 19



Vaccination consent form for children and young people

The COVID-19 vaccine is being offered to your child either as a 1st or 2nd dose. If your child has already received a 1st dose then you will need to use this form for your child's 2nd dose. If your child has not yet received their 1st dose then you can also use this form to provide consent.

Further information can be found on the DfE website:

<https://www.gov.uk/government/publications/covid-19-vaccination-resources-for-children-and-young-people>

Please discuss the vaccination with your child, then complete this form by:

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:	

Ask ALL patients ALL questions below and tick if any apply

EXCLUSION CHECKLIST – tick any that apply

- ☐ Has your child tested positive for COVID-19 in the last 12 weeks (by a lateral flow test or a PCR test)? If so, please provide the date on which your child tested positive: _____
- ☐ Has the individual experienced major venous and/or arterial thrombosis occurring with thrombocytopenia following vaccination with any COVID-19 vaccine?
- ☐ Has the individual had any vaccination in the last 7 days?
- ☐ Is the individual currently unwell with fever?
- ☐ Does the individual have an allergy to any medications?
- ☐ Has the individual ever had an anaphylactic reaction?
- ☐ Does the individual take any regular medication if so what? Please list: _____
- ☐ Does the individual have a history of heparin-induced thrombocytopenia and thrombosis (HITT or HIT type 2)?
- ☐ Does the individual have a history of capillary leak syndrome?
- ☐ None of the above

CAUTION CHECKLIST – tick any that apply

- ☐ Has the individual indicated they are, or could be pregnant?
- ☐ Has the individual informed you they are currently or have been in a trial of a potential coronavirus vaccine?
- ☐ Is the individual taking anticoagulant medication, or do they have a bleeding disorder?
- ☐ Does the individual currently have any symptoms of Covid-19 infection?
- ☐ None of the above

I want my child to receive the COVID-19 vaccination	I do not want my child to have the COVID-19 vaccine
Name:	Name:
Signature: Parent/Guardian	Signature: Parent/Guardian
Date:	Date:

If after discussion, you and your child decide that you do not want them to have the vaccine, it would be helpful if you would give the reasons for this on the back of this form.

Ask for the What to expect after your COVID-19 vaccination leaflet at gov.uk/government/publications/covid-19-vaccination-resources-for-children-and-young-people. It will tell you about the side effects and how to report them to the Yellowcard scheme at yellowcard.mhra.gov.uk.

OFFICE USE ONLY						
Date of COVID-19 vaccination		Site of injection (please circle)		Batch number/ expiry date	Immuniser (please print)	Where administered (hub, PCN, GP etc)
First		L arm	R arm			
Second		L arm	R arm			