Covid 19

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. 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.
Please complete in black or blue ink.

Student Details

Child's full name (first name and surname):

Home address:

Post code:

Date of birth:

Daytime contact telephone number for parent/carer:

NHS Number (if known):

Ethnicity:

GP Name:

School (if relevant):

GP address:

Year group/class:

Has your child ever had a severe allergic reaction or anaphylaxis which needed hospital admission or resuscitation? Yes ☐ No ☐

Does your child have any medical conditions?
Please give details: Yes ☐ No ☐

Is this your child's first COVID vaccine? Yes ☐ No ☐

Has your child had a positive PCR test for COVID in the last 28 days? Yes ☐ No ☐

Consent for COVID-19 vaccination (please complete one box)

☐ YES, I WANT my child to receive Pfizer COVID-19 vaccination.

☐ NO, I DO **NOT** WANT my child to have the COVID-19 vaccine.

Name:

Signature of the parent /guardian with parental responsibility:

Date:

Name:

Signature of the parent /guardian with parental responsibility:

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 a reason below:

OFFICE USE ONLY

Pre vaccination assessment

Is the child well today?	Yes ☐ No ☐
Does the child have any allergies?	Yes ☐ No ☐
Is the child taking any medication?	Yes ☐ No ☐
Has the child had a positive PCR test within the last 28 days?	Yes ☐ No ☐
Are there any other contraindications?	Yes ☐ No ☐
Is there any chance the child could be pregnant?	Yes ☐ No ☐
Has the child had another vaccination in the last 7 days?	Yes ☐ No ☐

Vaccines administered under a protocol/PGD

Date of COVID Vaccination and Time		Site of Injection		Batch Number/ Exp date	Immuniser name	Immuniser signature
FIRST		**L** Arm	**R** Arm	Pfizer 0.3ml		

Name of person reconstituting vaccine: .....

Uploaded to NIVS by: .....