COVID-19 vaccination **consent form**

Person

Surname _____ First name _____

Phone _____ Date of birth ___ / ___ / ___ Age _____ years

Address _____

Medical Centre/GP _____ NHI _____

Please let the vaccinator know:

- If you are unwell
- If you are pregnant
- If you're on blood-thinning medications or have a bleeding disorder
- If you've had a previous severe allergic reaction to any vaccine or injection in the past

If you are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years you will get the paediatric dose
- If you have had myocarditis or pericarditis after a vaccination in the past

If you are receiving AstraZeneca, please let your vaccinator know:

- If you are aged under 18 years
- If you are pregnant
- If you've ever had a major clot or low blood platelets in the past, or have an autoimmune condition that means you are more likely to have a clot
- If you've ever had capillary leak syndrome, a rare condition causing fluid leakage from small blood vessels

☐ I have read the COVID-19 information provided, 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 I will need 2 doses of the COVID-19 vaccine to be fully vaccinated.

☐ I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.

☐ I understand the side effects associated with this vaccine and know how to get help if needed.

Signature _____ Date ___ / ___ / ___

Parent / legal guardian / enduring power of attorney

I am the parent, legal guardian or enduring power of attorney, and agree to the COVID-19 vaccination of the person named above.

Name of parent or legal guardian _____

Relationship to person being vaccinated _____

Signature _____ Date ___ / ___ / ___

Tick the vaccine dose that applies:

Paediatric Pfizer	Dose 1 5-12 years ☐	Dose 2 5-12 years ☐		
Pfizer	Dose 1 12 years and above ☐	Dose 2 12 years and above ☐	Dose 3* 12 years and above ☐	Booster 18 years and above ☐
AstraZeneca	Dose 1 18 years and above ☐	Dose 2** 18 years and above ☐	Dose 3* 18 years and above ☐	Booster* 18 years and above ☐

I understand that I am receiving a vaccine as indicated above and understand the information given to me.

Signature _____ Date ___ / ___ / ___

* These doses are considered off-label use.
** AstraZeneca as a second primary dose following a non-AstraZeneca dose is considered off-label use.

Authorised prescriber (incl. medical practitioner, nurse practitioner or pharmacy prescriber)

I confirm that I have explained the reasons for, the risks and outcomes of the **Pfizer** or **AstraZeneca** vaccination to the person named on this consent form. (please circle one)

Signature _____ Date ___ / ___ / ___

PLEASE NOTE: A prescription from an authorised prescriber is required for a third primary dose of Pfizer. A prescription is recommended for AstraZeneca as a booster dose or a second primary (ie. following a non-AstraZeneca vaccine for dose 1).

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 _____

Vaccine							Diluent (Pfizer only)		
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
AstraZeneca			0.5mL						

Paediatric Pfizer	Dose 1 5-12 years ☐	Dose 2 5-12 years ☐		
Pfizer	Dose 1 12 years and above ☐	Dose 2 12 years and above ☐	Dose 3* 12 years and above ☐	Booster 18 years and above ☐
AstraZeneca	Dose 1 18 years and above ☐	Dose 2** 18 years and above ☐	Dose 3* 18 years and above ☐	Booster* 18 years and above ☐

* These doses are considered off-label use.
** AstraZeneca as a second primary dose following a non-AstraZeneca dose is considered off-label use.

Vaccinator information

Name _____

Signature _____

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature _____

Departure time _____

Vaccination site clinical lead

If administering an off-label use, such as a third primary dose, AstraZeneca vaccine as a booster dose OR AstraZeneca as the secondary dose of the primary course (ie following non-AstraZeneca COVID-19 vaccine for dose 1), this should be signed below by the clinical lead.

Name _____

Signature _____ Date ___ / ___ / ___

When a prescription is used, the prescriber must retain this form or a copy, and hold securely as a medical record in accordance with local policy.

Te Kāwanatanga o Aotearoa
New Zealand Government

Unite against COVID-19

MINISTRY OF HEALTH
MANATŪ HAUORA