COVID-19 vaccination consent form

Patient

Person

Surname ______________________ First name ______________________

Phone ______________________ Date of birth ___ / ___ / _____ (DD / MM / YYYY) Age _____ years

Address ______________________

Medical Centre/GP ______________________ NHI ____________
National Health Index number if known

Ethnicity (please tick one or more)

☐ NZ European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean ☐ Chinese

☐ Indian ☐ Other – please state ______________________

Consent statements

☐ I have read the fact sheet called 'What you need to know about the COVID-19 vaccination'.

☐ I confirm that the vaccinator has discussed with me whether COVID-19 vaccination is recommended for me based on my age, health status, and current recommendations.

☐ I have been told how long I will need to wait after the vaccination.

☐ The benefits and risks of the COVID-19 vaccine have been explained to me.

☐ The common and rare side effects of the COVID-19 vaccine have been explained to me.

☐ I had enough time to ask questions and my questions were answered to my satisfaction.

☐ I have received or photographed the fact sheets so I can refer to them after I leave the appointment.
- 'What you need to know about the COVID-19 vaccination'
- 'After the COVID-19 vaccination'

☐ I understand this vaccination will be recorded on the Aotearoa Immunisation Register (AIR) and shared with my/the vaccinated person's regular healthcare provider, and I have been provided with AIR privacy information.

☐ The vaccinator has discussed with me other vaccines I am eligible for.

☐ I was told how and when to seek assistance if I/ the person being vaccinated experience symptoms that may be vaccine related.

☐ **I consent to the COVID-19 vaccination being given.**

Signature ______________________ Date ___ / ___ / _____ (DD / MM / YYYY)

As 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.

Relationship to person being vaccinated ______________________ Phone ______________________

Signature ______________________ Date ___ / ___ / _____ (DD / MM / YYYY)

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Doses requiring prescription

Prescriber (incl. medical practitioner, nurse practitioner or pharmacist prescriber)

I confirm that I have explained the reasons for and the risks and benefits of the **Pfizer COVID-19** vaccination to the person named on this consent form.

Prescriber's name ______________________ MCNZ/APC number ______________

Signature ______________________ Date ___/___/_____ (DD/MM/YYYY)

Vaccination site clinical lead

When administering an off-label dose of vaccine, the clinical lead signs as an informed consent final check with the consumer.

Name ______________________

Signature ______________________ Date ___/___/_____ (DD/MM/YYYY)

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.

Vaccination record (for vaccinator use)

Consumer details confirmed ☐ Affirmative answer to any screening questions? ☐ Yes ☐ No

If yes, record the detail and advice given ______________________

Verbal and written post vaccination information given ☐ Informed consent obtained? ☐ Yes ☐ No

AIR checked to ensure recommended dose interval before administration ☐

COVID-19 vaccination primary course			COVID-19 vaccination additional dose
Pfizer Comirnaty (3mcg) 6 months - 4 years	**Pfizer** Comirnaty (10mcg) 5 – 11 years	**Pfizer** Comirnaty (30mcg) 12 years and over	**Pfizer** Comirnaty All ages from 6 months, if eligible
Dose 1 ☐	Dose 1 ☐	Dose 1 ☐	Dose ________ ☐
Dose 2 ☐	Dose 2* ☐	Dose 2* ☐	
Dose 3 ☐	Dose 3* ☐	Dose 3* ☐	

* If eligible
- Clinical discretion can be applied to dose interval; following a documented informed consent discussion, written consent is strongly recommended. Refer to Immunisation Handbook.

Vaccine details							Diluent (Comirnaty 3mcg)		
Name of vaccine	Batch	Expiry	Dose	Site	Date	Time	Batch	Expiry	Time of reconstitution

Vaccinator information

Place of vaccination ______________________

____

Name ______________________

Signature ______________________

Observation period

☐ Details of any AEFI or observations recorded

☐ CARM report completed

Signature ______________________

Departure time ______________________

Te Kawanatanga o Aotearoa
New Zealand Government

Health New Zealand
Te Whatu Ora