COVID-19 vaccination **consent form**

Patient

Surname ______________________ First name ______________________

Phone ________________ Date of birth ___ / ___ / ___ NHI __________

Address ____

Medical Centre/GP ____________________________

Guardian / enduring power of attorney

Name of guardian (if applicable) ____

Guardian's 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 are pregnant
- If you are aged under 16 years

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

I understand I will need 2 doses of the Pfizer COVID-19 vaccine to have the best protection.

Signature ______________________ **Date** ___ / ___ / ___

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

Signature ______________________ **Date** ___ / ___ / ___

New Zealand Government

Unite against COVID-19

HP7565 | 6 May 2021

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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MINISTRY OF HEALTH
MANATŪ HAUORA