

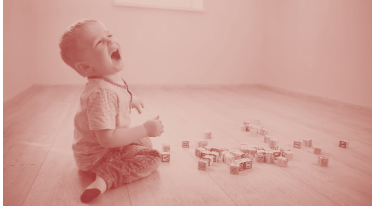


Consent Form for children aged 6 months - 4 years

COVID-19 vaccine - Spring 2024

Please scan the QR code to access information about your child's vaccine and what to expect. It will also explain how to report suspected side effects or adverse reactions via the Yellowcard scheme. If you require this information in an alternative format, this can be provided by contacting 111 or when you attend your child's appointment.

Child's full name (first name and surname):
Home address:
Email address for the parent/carer (optional):
NHS number (if known):
GP Practice:

Date of birth:	Age
Date of Last Dose:	If unknown this will be completed when you attend your appointment.

Consent for a Covid-19 Vaccination

I want my child to receive a dose of COVID-19 vaccination
Parent / Carer Name (Legal Guardian):
Relationship to child:
Daytime contact telephone number for parent or carer:
Signature:
Date:

Confirmation of vaccine booked in for: (Please circle)

Spring 2024 / Primary Dose

Please remember to complete the other side of this form

Office use only

Medicine Prescribed	Dose (mcg)	Route	Freq	Date	Vaccine Patient Specific Direction *(for Doctors only)*	Print name and signature	GMC No.
		I / M	Stat	DD / MM / YY			

Date of vaccination	Time	Vaccine Dose (mcg)	Site of injection *(please circle)*				Batch Number	Expiry date	Brand of Vaccine
DD / MM / YY	00 : 00		Left Arm	Right Arm	Left Thigh	Right Thigh		MM / YY	

Immuniser name and signature **(PLEASE PRINT)**	Where administered *(hub etc)*
Clinical Notes:	

manx care
Kiarail Vannin

Manx Care (Primary Care) is committed to protecting your privacy and will only process personal confidential data in accordance with Data Protection Act 2018, the Data Protection (Application of GDPR) Order 2018, the Common Law Duty of Confidentiality and the Human Rights Act 2001
for details visit gov.im/manxcare-privacy.

Manx Care, Noble's Hospital, Strang, Braddan, Isle of Man IM4 4RJ Telephone (01624) 650 000.

Adapted from Manx Care Pfizer Consent Form IMM 102 05/2021 V4

Ref: IMM112e 03/2024 (MC202277)

Eligibility Criteria

	Yes	No
Adults aged 75 years and over		
Residents in a care home for older adults		
Individuals aged six months and over who are defined as immunosuppressed (as defined in tables 3 or 4 in the COVID-19 chapter of the Green Book) If yes, please specify the condition and/or treatment that affects their immune system.		

PRE-ASSESSMENT QUESTIONNAIRE *(Please circle the following)*

Protecting the staff: if you answer YES to the next group of questions your child will be assessed by a member of the Vaccination team.		
Is your child currently COVID-19 positive?	**Yes**	**No**
Is your child feeling unwell today or suffering from a high temperature or fever today?	**Yes**	**No**
If you answer **YES** to the next group of questions please inform the clinical staff as **YOUR CHILD MAY NOT** be able to have the vaccination today		
Has your child had a previous systemic allergic reaction (including immediate onset anaphylaxis) to a previous dose of a COVID-19 vaccination or to any component of the vaccine or residues from the manufacturing process? *(Refer to Product Information Leaflet for a full list of the ingredients)* *(Refer to guidance in Green Book Chapter 14a for administration of a subsequent dose if allergic reaction to first dose.)*	**Yes**	**No**
Does your child have a history of: • *immediate anaphylaxis to multiple, different drug classes, with the trigger unidentified (this may indicate Poly Ethylene Glycol (PEG) allergy);* • *anaphylaxis to a vaccine, injected antibody preparation or a medicine likely to contain PEG (such as depot steroid injection, laxative); or* • *idiopathic anaphylaxis?*	**Yes**	**No**
Has your child experienced myocarditis or pericarditis determined as likely to be related to previous COVID-19 vaccination?	**Yes**	**No**
Has your child experienced Capillary leak syndrome?	**Yes**	**No**
The following questions correspond to cautions in relation to the COVID-19 vaccine. If you have questions please read the information leaflet or discuss with the clinical staff.		
Do they have a bleeding disorder?	**Yes**	**No**
Are they taking any blood thinners?	**Yes**	**No**
Have they experienced Guillain-Barre Syndrome (GBS) following a COVID-19 vaccination?	**Yes**	**No**
Are they participating in a clinical trial of COVID -19 vaccines? (To be referred back to trial investigators for approval before vaccinating)	**Yes**	**No**
I can confirm that I have been given access to a copy of the Patient Information Leaflet (PIL)	**Yes / QR code provided**	**Declined**