Consent Form 16+ years

COVID-19 vaccine - Spring 2024

Please scan the QR code to access information about your 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 appointment.

Full name (first name and surname):
Home address:
Email address (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 to receive a dose of COVID-19 vaccination
Signature:
Date:
Telephone Number:

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 *(care home, 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

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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 your immune system.		

PRE-ASSESSMENT QUESTIONNAIRE

(Please circle the following)

Protecting the staff: if you answer YES to the below you will be assessed by a member of the Vaccination team.		
Are you currently COVID-19 positive?	Yes	No
Are you feeling unwell 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 YOU MAY NOT be able to have the vaccination today		
Have you 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
Do you 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
Have you experienced myocarditis or pericarditis determined as likely to be related to previous COVID-19 vaccination?	Yes	No
Have you 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 you have a bleeding disorder?	Yes	No
Are you taking any blood thinners?	Yes	No
Have you experienced Guillain-Barre Syndrome (GBS) following a COVID-19 vaccination?	Yes	No
Are you 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