Consent Form for children and young people aged 12-17 years (All dose types)

Comirnaty® COVID-19 mRNA vaccine

The COVID-19 vaccine is being offered to your child. Your child will receive their first COVID-19 vaccine and you may be notified about the second dose later. The leaflet sent with this form includes more information about the vaccines currently in use. Please discuss the vaccination with your child, then complete this form before it is due. Information about the vaccinations will be put on your child's health records.

Child's full name (first name and surname):	Date of Birth: / Age: / Ethnicity:
Home address:	Daytime contact telephone number for parent or carer:
NHS Number (if known)	Gender: ☐ Male ☐ Female ☐ Prefer not to say
GP Name and address	School (if relevant): / Year group/class:
	Date of last vaccination (1st or 2nd dose):

Consent for COVID-19 Vaccinations

I **want /do not want*** my child to receive the full course of COVID-19 Vaccinations

Parent / Carer Name (Legal Guardian):	
Relationship to child:	
Signature:	Date:

*Delete as appropriate

If, after discussion, you decide that you do not want to have the vaccine, it would be helpful if you would give the reasons for this below.

Download the **'What to expect after your COVID-19 vaccination'** leaflet at gov.im/vaccinations. Also read the Patient Information Leaflet for more details on the vaccine and possible side effects. You can also report any suspected side effects by visiting yellowcard.mhra.gov.uk or by downloading the Yellow Card App.

Please remember to complete the other side of this form

Office use only

Vaccine Patient Specific Direction *(for Doctors only)*	Dose	Route	Freq	Date	Signature	GMC No.
Comirnaty® COVID-19 mRNA vaccine	30 micrograms in 0.3mL	I / M	Stat	DD / MM / YY		

Date of vaccination	Time	Vaccine Dose			Site of injection *(please circle)*				Priority Group	Batch Number	Expiry date	Brand of Vaccine
DD / MM / YY	00 : 00	1st	2nd	3rd/ Booster	Left Arm	Right Arm	Left Thigh	Right Thigh			MM / YY	Pfizer/BioNTech

Immuniser name and signature *(please print)*	Where administered *(care home etc)*

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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Adapted from Manx Care Pfizer Consent Form IMM 102 05/2021 V3

PRE-ASSESSMENT QUESTIONNAIRE

Protecting the staff: if they answer YES to the questions below please advise the parent/carer and child to go straight home and follow current government guidance.		
Does your child have any symptoms of COVID-19? These may include:		
• New continuous cough?	**Yes**	**No**
• Loss of taste and/or smell?	**Yes**	**No**
• A fever?	**Yes**	**No**
• New shortness of breath?	**Yes**	**No**
Are they waiting for a COVID-19 test?	**Yes**	**No**
If you have answered yes to any of the above questions, you and your child should immediately go home, self-isolate and phone 111 for a COVID-19 test.		
If they answer **YES** to the next group of questions please inform the clinical staff as **THEY WILL 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 Comirnaty® COVID-19 mRNA vaccine 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**
Is your child suffering from a high temperature or fever? *[Patients suffering from acute severe febrile illness are excluded under the PGD, the presence of a minor infection is not a contraindication for vaccination]*	**Yes**	**No**
Has your child received a dose of COVID-19 vaccine within the last 28 days?	**Yes**	**No**
Has your child already completed a full course of COVID -19 vaccination?	**Yes**	**No**
Has your child had Covid -19 or tested positive for Covid -19 in the last 12 weeks? *(If your child is in an 'at risk' priority group (PG 6, PG 18 or PG 19) this time period is reduced to 28 days)*	**Yes**	**No**
The following questions relate to cautions in relation to the COVID-19 mRNA vaccine. If you have questions please read the information leaflet or discuss with the clinical staff.		
Does your child have a condition or receive treatment that severely affects their immune system?	**Yes**	**No**
Has your child received any other vaccination in the past 7 days? *(It should not be routine to offer appointments to give this vaccine at the same time as other vaccines. Scheduling should ideally be separated by an interval of at least 7 days to avoid incorrect attribution of potential adverse events, individuals should be informed about the likely timing of potential adverse events relating to each vaccine.)*	**Yes**	**No**
Does your child have a bleeding disorder?	**Yes**	**No**
Are they taking any blood thinners?	**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**
Is your child feeling unwell today?	**Yes**	**No**
If you have answered YES to any of the questions above you MUST speak to a Healthcare Practitioner for further advice.		
I can confirm that I have received and read a copy of the Patient Information Leaflet (PIL).	**Yes**	