mRNA COVID-19 Vaccine Consent Form

A COVID-19 vaccination reduces the severity of COVID-19 infection in the majority of people who are over 50 yrs. The benefit lasts between one and six months. If you have an underlying health condition, or are elderly, the booster dose may reduce the chance of your being admitted to hospital.

You still need to follow guidance in your workplace, which may include wearing personal protection equipment and taking part in screening programmes.

Like all medicines, vaccines can cause side effects. Most side effects are short-term, and not everyone gets them.

There is also a small risk of very rare adverse effects including sustained vaccine injury or death. For medico-legal reasons we are obliged to bring to your attention the detailed list of the potential adverse effects that have been reported via the 'yellow card' scheme (See **https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions/coronavirus-vaccine-summary-of-yellow-card-reporting**, or ask us for a copy). You can also report suspected side effects on that website or via the Yellow Card app. Visit **coronavirus-yellowcard.mhra.gov.uk**

Full name (first name and surname):
Home address:
NHS number (if known):
GP Practice and address:

Date of birth:	Age
Date of Last Dose:	Last vaccine dose type:

Consent for a Covid-19 Vaccination

I want to receive a dose of COVID-19 vaccination
Signature:
Date:
Telephone Number:

Confirmation of vaccine dose booked in for:

Please remember to complete the other side of this form

Office use only

Vaccine Patient Specific Direction *(for Doctors only)*	Dose Administered (mg)	Route	Freq	Date	Signature	GMC No.
		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		Left Arm	Right Arm	Left Thigh	Right Thigh			MM / YY	

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

Protecting the staff: if you answer YES to the below please go straight home and follow current government guidance.		
Do you 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 you waiting for a COVID-19 test?	**Yes**	**No**
If you answer **YES** to the next group of questions please inform the clinical staff as **YOU WILL 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**
Are you 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**
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**
Have you received a shingles vaccination in the past 7 days?	**Yes**	**No**
Have you contracted Covid-19 in the last 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.		
Are you breast feeding? *(There is no known risk associated with giving non-live vaccines whilst breastfeeding)*	**Yes**	**No**
Do you have a condition or receive treatment that severely affects your immune system?	**Yes**	**No**
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**
Are you 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**	**Declined**