mRNA COVID-19 Vaccine Consent Form

A COVID-19 vaccination will reduce the chance of you suffering from COVID-19 disease. Like all medicines, no vaccine is completely effective and it takes a few weeks for your body to boost its protection from the vaccine. Some people may still get COVID-19 despite having a vaccination, but this should lessen the severity of any infection. If you are currently pregnant, planning pregnancy or breastfeeding please read the detailed information at **gov.im/vaccinations**

The vaccine cannot give you COVID-19 infection, and this booster will continue to reduce your chance of becoming seriously ill. You will still need to follow the guidance in your workplace, including wearing the correct personal protection equipment and taking part in any screening programmes. Like all medicines, vaccines can cause side effects. Most of these are mild and short-term, and not everyone gets them.

Please read the patient information leaflet for more details on the vaccine and possible side effects by searching Coronavirus Yellow Card. You can also report suspected side effects on the same website or by downloading the Yellow Card app. Visit **coronavirus-yellowcard.mhra.gov.uk**

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

Date of birth:	Date of last dose:
Last vaccine dose type:	
Gender (circle as appropriate): ☐ Male ☐ Female ☐ Prefer not to say	

Consent for COVID-19 booster / Third primary dose vaccination

I want to receive the Booster / Third primary dose of COVID-19 vaccination
Name:
Signature:
Date

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.

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 Schedule (1st/2nd/3rd/1stB/2ndB)	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 (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

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 have answered yes to any of the above questions, you should immediately go home, self-isolate and phone 111 for a COVID-19 test.		
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 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	