Consent Form 16+ years

COVID-19 vaccine (Autumn)

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.

Details of Person to Receive Vaccinations

Full name (first name and surname):	Daytime contact telephone number:
Home address:	Date of birth: / Age: / Date of last vaccination:
NHS number (if known):	GP name and address:

YES ☐ NO ☐ I want to receive a dose of COVID-19 vaccination

YES ☐ NO ☐ I want to receive a dose of COVID-19 and the Seasonal Flu vaccination

YES ☐ NO ☐ Have you already received your seasonal flu vaccine for September 2023 - February 2024?

Signature:

Please remember to complete the other side of this form

Office use only

Covid-19

Medication/vaccination prescribed *(for Prescriber only)*	Dose Administered (micrograms)	Route	Freq	Date	Signature and Print Name	GMC No.
		I / M	Stat			

Date of vaccination	Time	Vaccine Dose (micrograms)	Site of injection *(please circle)*				Batch Number	Expiry date	Brand of Vaccine
			Left Arm	Right Arm	Left Thigh	Right Thigh			

Immuniser name and signature **(PLEASE PRINT)**	Location administered *(care home, hub etc)*

Seasonal Flu

Medication/vaccination prescribed *(for Prescriber only)*	Dose Administered (micrograms)	Route	Freq	Date	Signature and Print Name	GMC No.
		I / M	Stat			

Date of vaccination	Time	Under 65's	Over 65's	Site of injection *(please circle)*				Batch Number	Expiry date	Brand of Vaccine
				Left Arm	Right Arm	Left Thigh	Right Thigh			

Immuniser name and signature **(PLEASE PRINT)**	Location administered *(care home, hub 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

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

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Eligibility Criteria	Yes	No	Clinical Notes
aged 65 years or older			
residents in a care home for older adults			
frontline health and social care workers			
aged 12 to 64 in a clinical risk group*			
aged 12 to 64 who are household contacts of people with immunosuppression*			
aged 12 to 64 who are carers*			

* as defined in the Immunisation Green Book found at https://www.gov.uk/government/publications/covid-19-the-green-book-chapter-14a

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 or Seasonal Flu 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)*	**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 relate to cautions in relation to the COVID-19 and Seasonal Flu vaccines. If you have questions please read the information leaflet or discuss with the clinical staff.		
Do you have a condition or receive treatment that severely affects your immune system? If yes, please specify the condition or treatment that affects your immune system below:	**Yes**	**No**
Do you have any underlying health conditions?	**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**
I can confirm that I have been given access to a copy of the Patient Information Leaflet (PIL)	**Yes / QR code provided**	**Declined**