

Consent Form for children aged 5 - 11 years

COVID-19 vaccine - Spring 2024

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



I want my child to receive a dose of COVID-19 vaccination	Child's full name	(tirst nan	ne ana su								
Relationship to child: Daytime contact telephone number for parent or carer: NHS number (if known): GP Practice: Date of birth: Date of Last Dose: If unknown this will be completed when you attend your appointment: Please remember to complete the other side of this form Office use only Medicine Prescribed Prescribed Dose (mcg) I/M Stat DD / MM/ YY Date of Last Dose Site of injection (please arcle) Number (for Doctors only) Date of Last Dose Site of injection (please arcle) Number Expiry date Brand of Vaccine Do / MM/ YY Nere administered (hub etc)							I want	my child to rece	eive a dose of CC	OVID-19 v	accination
Email address for the parent/carer (optional): NHS number (if known): Signature: Date of birth: Date of Last Dose: Date of Last Dose: If unknown this will be completed when you attend your appointment. Please remember to complete the other side of this form Please remember to complete the other side of this form Office use only Medicine Prescribed Print name and signature (PLEASE PRINT) Date of Immuniser name and signature (PLEASE PRINT) Daytime contact telephone number for parent or carer: Date: Confirmation of vaccine booked in for. (Please circle) Spring 2024 / Primary Dose Frint name and signature GMC No. Signature: Confirmation of vaccine booked in for. (Please circle) Spring 2024 / Primary Dose Spring 2024 / Primary Dose Office use only I/M Stat DD / MM/ YY Signature: Date of Union Patient Specific Direction (I/Or Doctors only) Email address for the parent or carer: Where administered (Pub etc)	Home address:						Parent /	Carer Name (Leg	al Guardian):		
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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 govim/manxcare-privacy.

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

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 their 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.					
Is your child currently COVID-19 positive?	Yes	No			
Is your child feeling unwell today or suffering from a high temperature or fever today?					
If you answer YES to the next group of questions please inform the clinical staff as YOU MAY NOT be able to have vaccination today	e the				
Has your child 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			
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			
Has your child experienced myocarditis or pericarditis determined as likely to be related to previous COVID-19 vaccination?	Yes	No			
Has your child experienced Capillary leak syndrome?	Yes	No			
The following questions correspond to cautions in relation to the COVID-19 vaccine. If you have questions please releaflet or discuss with the clinical staff.	ead the infor	mation			
Do they have a bleeding disorder?	Yes	No			
Are they taking any blood thinners?	Yes	No			
Have they experienced Guillain-Barre Syndrome (GBS) following a COVID-19 vaccination?	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			
I can confirm that I have been given access to a copy of the Patient Information Leaflet (PIL)	Yes / QR code provided	Decline			