# COVID-19 vaccination consent form

**Patient**

**Person**

Surname _____ First name _____

Phone _____ Date of birth ___/___/_____ Age _____ years
DD MM YYYY

Address _____

Medical Centre/GP _____ NHI _____
National Health Index number if known

**Ethnicity (please tick one or more)**

☐ NZ European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean ☐ Chinese

☐ Indian ☐ Other – please state _____

**Consent statements**

- ☐ I have read the fact sheet called 'What you need to know about the COVID-19 vaccination'.
- ☐ I confirm it has been over 6 months since I/the person being vaccinated have had a positive COVID-19 test.
- ☐ I know I will need to wait at least 15 minutes after the vaccination.
- ☐ The benefits and risks of the COVID-19 vaccine have been explained to me.
- ☐ The common and rare side effects of the COVID-19 vaccine have been explained to me.
- ☐ I had enough time to ask questions and my questions were answered to my satisfaction.
- ☐ I have received or photographed the fact sheets so I can refer to them after I leave the appointment.
  - 'What you need to know about the COVID-19 vaccination'
  - 'After the COVID-19 vaccination'
- ☐ I understand this vaccination will be recorded on the Aotearoa Immunisation Register (AIR) and shared with my/the vaccinated person's regular healthcare provider, and I have been provided with AIR privacy information.
- ☐ The vaccinator has discussed with me other vaccines I am eligible for.
- ☐ I was told how and when to seek assistance if I/ the person being vaccinated experience symptoms that may be vaccine related.
- ☐ **I consent to the COVID-19 vaccination being given.**

Signature _____ Date ___/___/_____
DD MM YYYY

**As parent / legal guardian / enduring power of attorney**

I _____ am the parent, legal guardian or enduring power of attorney, and agree to the COVID-19 vaccination of the person named above.

Relationship to person being vaccinated _____ Phone _____

Signature _____ Date ___/___/_____
DD MM YYYY

# Doses requiring prescription

## Prescriber (incl. medical practitioner, nurse practitioner or pharmacist prescriber)

I confirm that I have explained the reasons for and the risks and benefits of the **Pfizer COVID-19** vaccination to the person named on this consent form.

Prescriber's name _____ MCNZ/APC number _____

Signature _____ Date ___/___/_____ DD / MM / YYYY

## Vaccination site clinical lead

When administering an off-label dose of vaccine, the clinical lead signs as an informed consent final check with the consumer.

Name _____

Signature _____ Date ___/___/_____ DD / MM / YYYY

When a prescription is used, the prescriber must retain this form or a copy, and hold securely as a medical record in accordance with local policy.

# Vaccination record (for vaccinator use)

Consumer details confirmed ☐ Affirmative answer to any screening questions? ☐ Yes ☐ No

If yes, record the detail and advice given _____

Verbal and written post vaccination information given ☐ Informed consent obtained? ☐ Yes ☐ No

Confirmed consumer has not tested positive for COVID-19 in the last 6 months ☐

AIR checked to ensure recommended dose interval before administration ☐

| COVID-19 vaccination primary course | | | | | | COVID-19 vaccination additional dose |
|---|---|---|---|---|---|---|
| **Pfizer** Comirnaty (3mcg) 6 months - 4 years | | **Pfizer** Comirnaty (10mcg) 5 – 11 years | | **Pfizer** Comirnaty (30mcg) 12 years and over | | **Pfizer** Comirnaty All ages from6 months, if eligible |
| Dose 1 | ☐ | Dose 1 | ☐ | Dose 1 | ☐ | Dose _____ ☐ |
| Dose 2 | ☐ | Dose 2* | ☐ | Dose 2* | ☐ | |
| Dose 3 | ☐ | Dose 3* | ☐ | Dose 3* | ☐ | |

* If eligible

- Clinical discretion can be applied to dose interval; following a documented informed consent discussion, written consent is strongly recommended. Refer to Immunisation Handbook.

| Vaccine details | | | | | | | Diluent (Comirnaty 3mcg) | | |
|---|---|---|---|---|---|---|---|---|---|
| Name of vaccine | Batch | Expiry | Dose | Site | Date | Time | Batch | Expiry | Time of reconstitution |
| | | | | | | | | | |

### Vaccinator information

Place of vaccination _____

_____

Name _____

Signature _____

### Observation period

☐ Details of any AEFI or observations recorded

☐ CARM report completed

Signature _____

Departure time _____

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