COVID-19 vaccination **consent form**

Patient

Surname ______________________ First name ______________________

Phone ________________ Date of birth ___ / ___ / ___ NHI ___________

Address ____

Medical Centre/GP ____________________________

Please let the vaccinator know:

- If you are unwell
- If you are aged under 12 years
- If you are pregnant
- If you're on blood-thinning medications or have a bleeding disorder
- If you've had a previous severe allergic reaction to any vaccine or injection in the past
- If you have had myocarditis or pericarditis after a vaccination in the past

I have read the COVID-19 information provided, and/or have had explained to me information about the COVID-19 vaccine.

I have had a chance to ask questions and they were answered to my satisfaction.

I believe I understand the benefits and risks of COVID-19 vaccination.

I understand it is my choice to get the COVID-19 vaccination.

I understand I will need 2 doses of the Pfizer COVID-19 vaccine to have the best protection.

Signature ______________________ Date ___ / ___ / ___

Parent / guardian / enduring power of attorney

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

Name of parent or guardian Relationship to patient

Signature ______________________ Date ___ / ___ / ___

Third primary dose

I understand I am receiving a third primary dose to provide increased protection against COVID-19.

Signature ______________________ Date ___ / ___ / ___

Medical practitioner

I confirm I have explained the reasons for, the risks and outcomes of a third primary vaccination to the consumer named above.

Signature ______________________ Date ___ / ___ / ___

PLEASE NOTE: A prescription from a medical practitioner is required for a third primary dose.

Te Kāwanatanga o Aotearoa
New Zealand Government

Unite against COVID-19

MINISTRY OF HEALTH
MANATŪ HAUORA

HP7565 | 21 October 2021

Information for Vaccinator

Details confirmed ☐

Positive answer to any screening questions? Yes ☐ No ☐

Record information and advice given:

Informed consent obtained? Yes ☐ No ☐

Date ___ / ___ / ___ Time ________

If deferred, declined or not medical fit for vaccine record detail ____________________

____

Vaccine							Diluent		
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Pfizer/BioNTech COVID-19 Vaccine			0.3ml						

Dose 1 ☐ Dose 2 ☐ Dose 3 ☐

Post vaccination information given ☐

Signature of vaccinator ________________

Name of vaccinator ________________

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ________________

Departure time ________

Vaccination site clinical lead

If administering a third primary dose, this should be signed below by the clinical lead.

Name ________________

Signature ________________ Date ___ / ___ / ___

In the case of a third primary dose, the prescriber must retain this form or a copy, and hold securely as a medical record in accordance with local policy.