COVID-19 **vaccination consent form**

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 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 was told how and when to seek assistance if I/ the person being vaccinated experience symptoms that may be vaccine related.

☐ I understand this vaccination information will be recorded and shared with my/the vaccinated person's regular healthcare provider.

☐ **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

Te Kāwanatanga o Aotearoa
New Zealand Government

Mā tātau katoa e ārai atu te COVID-19

Te Whatu Ora
Health New Zealand

Doses requiring prescription

Prescriber (incl. medical practitioner, nurse practitioner or pharmacist prescriber)
I confirm that I have explained the reasons for, the risks and benefits of the **Pfizer** or **Novavax** 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

Pfizer 6 months - 4 years	Dose 1 ☐	Dose 2 ☐	Dose 3 ☐		
Pfizer 5 - 11 years	Dose 1 ☐	Dose 2 ☐	Dose 3* ☐		
Pfizer 12 years and over	Dose 1 ☐	Dose 2 ☐	Dose 3* ☐	Booster 1 16 years and over ☐	Booster 2 For those eligible 16 years and over ☐
Novavax 12 years and over	Dose 1 ☐	Dose 2** ☐	Dose 3* ☐	Booster 1 18 years and over ☐	Booster 2 For those eligible 18 years and over ☐

* These doses are considered off-label use. Off-label does not apply to those receiving a third dose as part of their 6 month-4 year vaccine course.
** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label.

Vaccine details							**Diluent** Pfizer only		
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 _____