**COVID 19**

**Vaccination consent form for children and young people**

The COVID-19 vaccine is being offered to your child. Your child will receive their first COVID-19 vaccine and you will be notified about the second dose later. Please discuss the vaccination with your child, then complete this form to bring to their appointment

|  |  |
| --- | --- |
| Child’s full name (first name and surname): | Date of birth: |
| Home address: | Daytime contact telephone number for parent/carer: |
| NHS number (if known): | Ethnicity: |
| GP name and address: | |

**Consent for COVID-19 vaccination** (Please complete **one** box only)

|  |  |  |
| --- | --- | --- |
| I **want** my child to receive the COVID-19 vaccination |  | I **do not want** my child to have the COVID-19 vaccine |
| Name: | Name: |
| Signature:  Parent/Guardian | Signature:  Parent/Guardian |
| Date: | Date: |

If after discussion, you and your child decide that you do not want them to have the vaccine, it would be helpful if you would give the reasons for this on the back of this form.

**Ask for the What to expect after your COVID-19 vaccination leaflet at** [**gov.uk/government/publications/**](https://www.gov.uk/government/publications/covid-19-vaccination-resources-for-children-and-young-people)[**covid-19-vaccination-resources-for-children-and-young-people**](https://www.gov.uk/government/publications/covid-19-vaccination-resources-for-children-and-young-people)**. It will tell you about the side effects and how to report them to the Yellowcard scheme at** [**yellowcard.mhra.gov.u**](http://yellowcard.mhra.gov.uk/)**k.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| OFFICE USE ONLY | | | | | | |
| Date of COVID-19 vaccination | | Site of injection  (please circle) | | Batch number/ expiry date | Immuniser  (please print) | Where administered  ( hub, PCN, GP etc) |
| First |  | L arm | R arm |  |  |  |
| Second |  | L arm | R arm |  |  |  |

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**PLEASE TURN OVER**

**Checklist for children aged 12 to 15 year being vaccinated Pfizer BioNTech Covid-19 Vaccine**

**Please complete the following checklist for your child.**

|  |  |  |
| --- | --- | --- |
| **Has your child** | **If yes, please tick** | If you ticked the box, please provide further details |
| **Ever had a Covid vaccine before?**  (For example as part of a trial, or because they are in an at risk group) |  | What date(s)  Did they have any reaction or adverse events? |
| **Had an illness with a temperature (fever) in the last week?** |  |  |
| **Had any other vaccines in the last 7 days?** |  |  |
| **Got any long-term medical conditions that require on-going hospital treatment or are they waiting to see a specialist?** |  |  |
| **Had a positive Covid test in the last 12 weeks?** |  | If yes, what date(s) |
| **Ever had to go to hospital following a severe allergic reaction?** |  |  |

|  |
| --- |
| Name and signature of person completing this form: |
| Relationship to child: |
| Date form completed: |