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 may be notified about the second dose later. The leaflet sent with this form includes more information about the vaccines currently in use. Please discuss the vaccination with your child, then complete this form before it is due. Information about the vaccinations will be put on your child's health records.

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:
School (if relevant):	Year group/class:
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/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.uk.

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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Checklist for children aged 12 to 15 years being vaccinated in schools: Pfizer BioNTech COVID-19 Vaccine

Please complete the following checklist for your child. If you tick yes to any of the answers below, your school immunisation team may contact you for further information. Please let them know if anything changes before the date of your child's COVID-19 vaccination.

Has your child	**If yes, please tick**	If you ticked the box, please provide further details
Ever had a COVID-19 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 reactions 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 (including bleeding disorders) that require ongoing hospital treatment or are they waiting to see a specialist?	☐	
Had a positive COVID-19 test in the last 4 weeks?	☐	If yes, what date(s)
Ever had to go to the hospital following a severe allergic reaction?	☐	

Name of child:

Name of person with parental responsibility completing this form:

Relationship to child:

Home postcode: