

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 <input type="checkbox"/>	Dose 2 <input type="checkbox"/>	Dose 3 <input type="checkbox"/>		
Pfizer 5 - 11 years	Dose 1 <input type="checkbox"/>	Dose 2 <input type="checkbox"/>	Dose 3* <input type="checkbox"/>		
Pfizer 12 years and over	Dose 1 <input type="checkbox"/>	Dose 2 <input type="checkbox"/>	Dose 3* <input type="checkbox"/>	Booster 1 16 years and over <input type="checkbox"/>	Booster 2 For those eligible 16 years and over <input type="checkbox"/>
Novavax 12 years and over	Dose 1 <input type="checkbox"/>	Dose 2** <input type="checkbox"/>	Dose 3* <input type="checkbox"/>	Booster 1 18 years and over <input type="checkbox"/>	Booster 2 For those eligible 18 years and over <input type="checkbox"/>

* 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 _____