COVID-19 vaccination **consent form**

Patient

Surname ______________________ First name ______________________

Phone ________________ Date of birth __ / __ / __ NHI __________

Address ____

Medical Centre/GP ____________________________

Parent / guardian / enduring power of attorney

Name of parent or guardian (if applicable) ______________________________

Relationship to patient ____________________________

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 __ / __ / __

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

Signature ______________________ Date __ / __ / __

Released under the Official Information Act 1982

New Zealand Government

Unite against COVID-19

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 ☐

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 ________

Released under the Official Information Act 1982

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

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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.

Te Kāwanatanga o Aotearoa
New Zealand Government

Unite against COVID-19

MINISTRY OF HEALTH
MANATŪ HAUORA

Released under the Official Information Act 1982

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 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 are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years
- If you have had myocarditis or pericarditis after a vaccination in the past

If you are receiving AstraZeneca, please let your vaccinator know:

- If you are aged under 18 years
- If you've ever had a major clot or low blood platelets in the past, or have an autoimmune condition that means you are more likely to have a clot
- If you've ever had capillary leak syndrome, a rare condition causing fluid leakage from small blood vessels

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

I have been informed of the contraindications of 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 COVID-19 vaccine to be fully vaccinated.

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 ___ / ___ / ___

Tick the vaccine dose that applies:

Pfizer	AstraZeneca
Dose 1 ☐ Dose 2 ☐ Dose 3* ☐ Booster ☐	Dose 1 ☐ Dose 2** ☐ Dose 3* ☐ Booster* ☐

I understand that I am receiving a vaccine as indicated above and understand the information given to me.

Signature ______________________________ Date ___ / ___ / ___

* These doses are considered off-label use.
** AstraZeneca as a second primary dose following a non-AstraZeneca dose is considered off-label use.

Released under the Official Information Act 1982

Medical practitioner

I confirm that I have explained the reasons for, the risks and outcomes of the **Pfizer** or **AstraZeneca** vaccination to the patient named on this consent form. (please circle one)

Signature ______________________________ Date ___ / ___ / ___

PLEASE NOTE: A prescription from a medical practitioner is required for a third primary dose of Pfizer. A prescription is recommended for AstraZeneca as a booster dose or a second primary (ie. following a non-AstraZeneca vaccine for dose 1).

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 medically fit for vaccine, record detail:

Vaccine							Diluent (Pfizer only)		
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Pfizer/BioNTech COVID-19 Vaccine			0.3mL						
AstraZeneca			0.5mL						

Pfizer

Dose 1 ☐ Dose 2 ☐ Dose 3* ☐ Booster ☐

AstraZeneca

Dose 1 ☐ Dose 2** ☐ Dose 3* ☐ Booster* ☐

* These doses are considered off-label use.
** AstraZeneca as a second primary dose following a non-AstraZeneca dose is considered off-label use.

Vaccinator information

Name ______________________

Signature ______________________

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ______________________

Departure time ____________

Vaccination site clinical lead

If administering an off-label use, such as a third primary dose, AstraZeneca vaccine as a booster dose OR AstraZeneca as the secondary dose of the primary course (ie following non-AstraZeneca COVID-19 vaccine for dose 1), this should be signed below by the clinical lead.

Name ______________________________

Signature ______________________________ Date ___ / ___ / ___

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.

Released under the Official Information Act 1982

COVID-19 vaccination **consent form**

Person

Surname ______________ First name ______________

Phone ______________ Date of birth ___ / ___ / ___ Age _____ years

Address ______________

Medical Centre/GP ______________ NHI ______________

Please let the vaccinator know:

- If you are unwell
- 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 are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years you will get the paediatric dose
- If you have had myocarditis or pericarditis after a vaccination in the past

If you are receiving AstraZeneca, please let your vaccinator know:

- If you are aged under 18 years
- If you are pregnant
- If you've ever had a major clot or low blood platelets in the past, or have an autoimmune condition that means you are more likely to have a clot
- If you've ever had capillary leak syndrome, a rare condition causing fluid leakage from small blood vessels

☐ 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 I will need 2 doses of the COVID-19 vaccine to be fully vaccinated.

☐ I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.

☐ I understand the side effects associated with this vaccine and know how to get help if needed.

Signature ______________ Date ___ / ___ / ___

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.

Name of parent or legal guardian ______________

Relationship to person being vaccinated ______________

Signature ______________ Date ___ / ___ / ___

Tick the vaccine dose that applies:

Paediatric Pfizer	Dose 1 5-12 years ☐	Dose 2 5-12 years ☐		
Pfizer	Dose 1 12 years and above ☐	Dose 2 12 years and above ☐	Dose 3* 12 years and above ☐	Booster 18 years and above ☐
AstraZeneca	Dose 1 18 years and above ☐	Dose 2** 18 years and above ☐	Dose 3* 18 years and above ☐	Booster* 18 years and above ☐

I understand that I am receiving a vaccine as indicated above and understand the information given to me.

Signature ______________ Date ___ / ___ / ___

* These doses are considered off-label use.
** AstraZeneca as a second primary dose following a non-AstraZeneca dose is considered off-label use.

Released under the Official Information Act 1982

Authorised prescriber (incl. medical practitioner, nurse practitioner or pharmacy prescriber)

I confirm that I have explained the reasons for, the risks and outcomes of the **Pfizer** or **AstraZeneca** vaccination to the person named on this consent form. (please circle one)

Signature ______________________ Date ___ / ___ / ___

PLEASE NOTE: A prescription from an authorised prescriber is required for a third primary dose of Pfizer. A prescription is recommended for AstraZeneca as a booster dose or a second primary (ie. following a non-AstraZeneca vaccine for dose 1).

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 ________

Vaccine							**Diluent**		Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
AstraZeneca			0.5mL						

Paediatric Pfizer	Dose 1 5-12 years ☐	Dose 2 5-12 years ☐		
Pfizer	Dose 1 12 years and above ☐	Dose 2 12 years and above ☐	Dose 3* 12 years and above ☐	Booster 18 years and above ☐
AstraZeneca	Dose 1 18 years and above ☐	Dose 2** 18 years and above ☐	Dose 3* 18 years and above ☐	Booster* 18 years and above ☐

* These doses are considered off-label use.
** AstraZeneca as a second primary dose following a non-AstraZeneca dose is considered off-label use.

Vaccinator information

Name ______________________

Signature ______________________

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ______________________

Departure time ____________

Vaccination site clinical lead

If administering an off-label use, such as a third primary dose, AstraZeneca vaccine as a booster dose OR AstraZeneca as the secondary dose of the primary course (ie following non-AstraZeneca COVID-19 vaccine for dose 1), this should be signed below by the clinical lead.

Name ______________________

Signature ______________________ Date ___ / ___ / ___

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.

Released under the Official Information Act 1982

COVID-19 vaccination **consent form**

Person

Surname ______________ First name ______________

Phone ______________ Date of birth ___ / ___ / ___ Age _____ years

Address ______________

Medical Centre/GP ______________ NHI ______________

Please let the vaccinator know:

- If you are unwell
- If you are pregnant or breastfeeding
- 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 are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years you will get the paediatric dose
- If you have had myocarditis or pericarditis after a vaccination in the past

If you are receiving Novavax, please let your vaccinator know:

- If you are aged under 18 years

If you are receiving AstraZeneca, please let your vaccinator know:

- If you are aged under 18 years
- If you've ever had a major clot or low blood platelets in the past, or have an autoimmune condition that means you are more likely to have a clot
- If you've ever had capillary leak syndrome, a rare condition causing fluid leakage from small blood vessels

☐ 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 understand the benefits and risks of COVID-19 vaccination.

☐ I understand I will need 2 doses of the COVID-19 vaccine to be fully vaccinated.

☐ I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.

☐ I understand the side effects associated with this vaccine and know how to get help if needed.

Signature ______________ Date ___ / ___ / ___

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.

Name of parent or legal guardian ______________ Phone ______________

Relationship to person being vaccinated ______________

Signature ______________ Date ___ / ___ / ___

Tick the vaccine dose that applies:

Vaccine				
Paediatric Pfizer	Dose 1 5-12 years ☐	Dose 2 5-12 years ☐		
Pfizer	Dose 1 12 years and above ☐	Dose 2 12 years and above ☐	Dose 3* 12 years and above ☐	Booster 18 years and above ☐
AstraZeneca	Dose 1 18 years and above ☐	Dose 2** 18 years and above ☐	Dose 3* 18 years and above ☐	Booster* 18 years and above ☐
Novavax	Dose 1 18 years and above ☐	Dose 2** 18 years and above ☐		

I understand that I am receiving a vaccine as indicated above and understand the information given to me. I agree to receive the vaccine indicated above.

Signature ______________ Date ___ / ___ / ___

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label. **For any off-label use of a vaccine a prescription is required.**

Released under the Official Information Act 1982

Authorised prescriber (incl. medical practitioner, nurse practitioner or pharmacy prescriber)

I confirm that I have explained the reasons for, the risks and outcomes of the **Pfizer**, **AstraZeneca** or **Novavax** vaccination to the person named on this consent form.

(please circle one above)

Name ______________________ APC number ____________

Signature ______________________ Date ___ / ___ / ___

For prescription requirements please see the relevant Policy Statement.

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 ________

Vaccine							Diluent		Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
AstraZeneca			0.5mL						
Novavax			0.5mL						

Paediatric Pfizer	Dose 1 5-12 years ☐	Dose 2 5-12 years ☐		
Pfizer	Dose 1 12 years and above ☐	Dose 2 12 years and above ☐	Dose 3* 12 years and above ☐	Booster 18 years and above ☐
AstraZeneca	Dose 1 18 years and above ☐	Dose 2** 18 years and above ☐	Dose 3* 18 years and above ☐	Booster* 18 years and above ☐
Novavax	Dose 1 18 years and above ☐	Dose 2** 18 years and above ☐		

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label.

Vaccinator information

Name ______________________

Signature ______________________

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ______________________

Departure time __________

Vaccination site clinical lead

If administering an off-label use, this should be signed below by the clinical lead.

Name ______________________

Signature ______________________ Date ___ / ___ / ___

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.

Released under the Official Information Act 1982

COVID-19 vaccination **consent form**

Person

Surname ______________________ First name ______________________

Phone ________________ Date of birth ___ / ___ / _____ (DD MM YYYY) Age _____ years

Address ____

Medical Centre/GP ______________________________ NHI __________

Please let the vaccinator know:

- If you are unwell
- If you are pregnant or breastfeeding
- 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 are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years you will get the paediatric dose
- If you have had myocarditis or pericarditis after a vaccination in the past

If you are receiving Novavax, please let your vaccinator know:

- If you are aged under 18 years

If you are receiving AstraZeneca, please let your vaccinator know:

- If you are aged under 18 years
- If you've ever had a major clot or low blood platelets in the past, or have an autoimmune condition that means you are more likely to have a clot
- If you've ever had capillary leak syndrome, a rare condition causing fluid leakage from small blood vessels

☐ 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 understand the benefits and risks of COVID-19 vaccination.

☐ I understand I will need 2 doses of the COVID-19 vaccine to be fully vaccinated.

☐ I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.

☐ I understand the side effects associated with this vaccine and know how to get help if needed.

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

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.

Name of parent or legal guardian ______________________ Phone ____________

Relationship to person being vaccinated ______________________

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

Tick the vaccine dose that applies:

Paediatric Pfizer	Dose 1 5-11 years ☐	Dose 1 5-11 years ☐	Dose 3* 5-11 years ☐	
Pfizer	Dose 1 12 years and above ☐	Dose 2 12 years and above ☐	Dose 3* 12 years and above ☐	Booster 16 years and above ☐
AstraZeneca	Dose 1 18 years and above ☐	Dose 2** 18 years and above ☐	Dose 3* 18 years and above ☐	Booster* 18 years and above ☐
Novavax	Dose 1 18 years and above ☐	Dose 2** 18 years and above ☐		

I understand that I am receiving a vaccine as indicated above and understand the information given to me. I agree to receive the vaccine indicated above.

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label. **For any off-label use of a vaccine a prescription is required.**

Released under the Official Information Act 1982

Authorised prescriber (incl. medical practitioner, nurse practitioner or pharmacy prescriber)

I confirm that I have explained the reasons for, the risks and outcomes of the **Pfizer**, **AstraZeneca** or **Novavax** vaccination to the person named on this consent form.

(please circle one above)

Name ______________________ APC number ______________

Signature ______________________ Date ___ / ___ / _____ (DD MM YYYY)

For prescription requirements please see the relevant Policy Statement.

Information for Vaccinator

Details confirmed ☐ Positive answer to any screening questions? Yes ☐ No ☐

Record information and advice given:

Informed consent obtained? Yes ☐ No ☐ Date ___ / ___ / _____ (DD MM YYYY) Time ________

Vaccine							**Diluent**		Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
AstraZeneca			0.5mL						
Novavax			0.5mL						

Paediatric Pfizer	Dose 1 5-11 years ☐	Dose 1 5-11 years ☐	Dose 3* 5-11 years ☐	
Pfizer	Dose 1 12 years and above ☐	Dose 2 12 years and above ☐	Dose 3* 12 years and above ☐	Booster 16 years and above ☐
AstraZeneca	Dose 1 18 years and above ☐	Dose 2** 18 years and above ☐	Dose 3* 18 years and above ☐	Booster* 18 years and above ☐
Novavax	Dose 1 18 years and above ☐	Dose 2** 18 years and above ☐		

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label.

Vaccinator information

Name ______________________

Signature ______________________

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ______________________

Departure time __________

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.

Released under the Official Information Act 1982

COVID-19 vaccination **consent form**

Person

Surname ______________________ First name ______________________

Phone ________________ Date of birth ___ / ___ / _____ (DD MM YYYY) Age _____ years

Address ____

Medical Centre/GP ______________________________ NHI __________

Please let the vaccinator know:

- If you are unwell
- If you are pregnant or breastfeeding
- 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 are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years you will get the paediatric dose
- If you have had myocarditis or pericarditis after a vaccination in the past

If you are receiving Novavax, please let your vaccinator know:

- If you are aged under 18 years

If you are receiving AstraZeneca, please let your vaccinator know:

- If you are aged under 18 years
- If you've ever had a major clot or low blood platelets in the past, or have an autoimmune condition that means you are more likely to have a clot
- If you've ever had capillary leak syndrome, a rare condition causing fluid leakage from small blood vessels

- [ ] 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 understand the benefits and risks of COVID-19 vaccination.
- [ ] I understand I will need 2 doses of the COVID-19 vaccine to be fully vaccinated.
- [ ] I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.
- [ ] I understand the side effects associated with this vaccine and know how to get help if needed.

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

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.

Name of parent or legal guardian ______________________ Phone __________

Relationship to person being vaccinated ______________________

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

Tick the vaccine dose that applies:

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2* ☐ For those eligible 16 years and above
AstraZeneca	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Dose 3* ☐ 18 years and above	Booster* ☐ 18 years and above	
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above			

I understand that I am receiving a vaccine as indicated above and understand the information given to me. I agree to receive the vaccine indicated above.

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label. **For any off-label use of a vaccine a prescription is required.**

Released under the Official Information Act 1982

Authorised prescriber (incl. medical practitioner, nurse practitioner or pharmacy prescriber)

I confirm that I have explained the reasons for, the risks and benefits of the **Pfizer**, **AstraZeneca** or **Novavax** vaccination to the person named on this consent form.

(please circle one above)

Name ______________________ APC number ____________

Signature ______________________ Date ___ / ___ / ____ (DD MM YYYY)

For prescription requirements please see the relevant Policy Statement.

Information for Vaccinator

Details confirmed ☐ Positive answer to any screening questions? Yes ☐ No ☐

Record information and advice given:

Informed consent obtained? Yes ☐ No ☐ Date ___ / ___ / ____ (DD MM YYYY) Time ________

Vaccine							**Diluent**		Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
AstraZeneca			0.5mL						
Novavax			0.5mL						

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2* ☐ For those eligible 16 years and above
AstraZeneca	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Dose 3* ☐ 18 years and above	Booster* ☐ 18 years and above	
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above			

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label.

Vaccinator information

Name ______________________

Signature ______________________

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ______________________

Departure time ____________

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.

Released under the Official Information Act 1982

COVID-19 vaccination **consent form**

Person

Surname ______________________ First name ______________________

Phone ________________ Date of birth __ / __ / ____ (DD MM YYYY) Age _____ years

Address ____

Medical Centre/GP ______________________________ NHI __________

Please let the vaccinator know:

- If you are unwell
- If you are pregnant or breastfeeding
- 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 are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years you will get the paediatric dose
- If you have had myocarditis or pericarditis after a vaccination in the past

If you are receiving Novavax, please let your vaccinator know:

- If you are aged under 18 years

If you are receiving AstraZeneca, please let your vaccinator know:

- If you are aged under 18 years
- If you've ever had a major clot or low blood platelets in the past, or have an autoimmune condition that means you are more likely to have a clot
- If you've ever had capillary leak syndrome, a rare condition causing fluid leakage from small blood vessels

☐ 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 understand the benefits and risks of COVID-19 vaccination.

☐ I understand I will need 2 doses of the COVID-19 vaccine to be fully vaccinated.

☐ I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.

☐ I understand the side effects associated with this vaccine and know how to get help if needed.

Signature ______________________________ Date __ / __ / ____ (DD MM YYYY)

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.

Name of parent or legal guardian ______________________ Phone __________

Relationship to person being vaccinated ______________________

Signature ______________________________ Date __ / __ / ____ (DD MM YYYY)

Tick the vaccine dose that applies:

Vaccine					
Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2* ☐ For those eligible 16 years and above
AstraZeneca	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Dose 3* ☐ 18 years and above	Booster* ☐ 18 years and above	
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above			

I understand that I am receiving a vaccine as indicated above and understand the information given to me. I agree to receive the vaccine indicated above.

Signature ______________________________ Date __ / __ / ____ (DD MM YYYY)

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label. **For any off-label use of a vaccine a prescription is required.**

Released under the Official Information Act 1982

Authorised prescriber (incl. medical practitioner, nurse practitioner or pharmacy prescriber)

I confirm that I have explained the reasons for, the risks and benefits of the **Pfizer**, **AstraZeneca** or **Novavax** vaccination to the person named on this consent form.

(please circle one above)

Name ____________________ APC number ____________

Signature ____________________ Date ___ / ___ / ____ (DD MM YYYY)

For prescription requirements please see the relevant Policy Statement.

Information for Vaccinator

Details confirmed ☐ Positive answer to any screening questions? Yes ☐ No ☐

Record information and advice given:

Informed consent obtained? Yes ☐ No ☐ Date ___ / ___ / ____ (DD MM YYYY) Time ________

Vaccine							Diluent		Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
AstraZeneca			0.5mL						
Novavax			0.5mL						

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2* ☐ For those eligible 16 years and above
AstraZeneca	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Dose 3* ☐ 18 years and above	Booster* ☐ 18 years and above	
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above			

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label.

Vaccinator information

Name ____________________

Signature ____________________

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ____________________

Departure time ____________

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.

Released under the Official Information Act 1982

COVID-19 vaccination **consent form**

Person

Surname ______________________ First name ______________________

Phone ________________ Date of birth ___ / ___ / _____ (DD MM YYYY) Age _____ years

Address ____

Medical Centre/GP ______________________________ NHI __________

Please let the vaccinator know:

- If you are unwell
- If you are pregnant or breastfeeding
- 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 are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years you will get the paediatric dose
- If you have had myocarditis or pericarditis after a vaccination in the past

If you are receiving Novavax, please let your vaccinator know:

- If you are aged under 18 years

If you are receiving AstraZeneca, please let your vaccinator know:

- If you are aged under 18 years
- If you've ever had a major clot or low blood platelets in the past, or have an autoimmune condition that means you are more likely to have a clot
- If you've ever had capillary leak syndrome, a rare condition causing fluid leakage from small blood vessels

☐ 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 understand the benefits and risks of COVID-19 vaccination.

☐ I understand I will need 2 doses of the COVID-19 vaccine to be fully vaccinated.

☐ I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.

☐ I understand the side effects associated with this vaccine and know how to get help if needed.

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

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.

Name of parent or legal guardian ______________________ Phone __________

Relationship to person being vaccinated ______________________

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

Tick the vaccine dose that applies:

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2* ☐ For those eligible 16 years and above
AstraZeneca	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Dose 3* ☐ 18 years and above	Booster* ☐ 18 years and above	
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Booster ☐ 18 years and above		

I understand that I am receiving a vaccine as indicated above and understand the information given to me. I agree to receive the vaccine indicated above.

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label. **For any off-label use of a vaccine a prescription is required.**

Released under the Official Information Act 1982

Authorised prescriber (incl. medical practitioner, nurse practitioner or pharmacy prescriber)

I confirm that I have explained the reasons for, the risks and benefits of the **Pfizer**, **AstraZeneca** or **Novavax** vaccination to the person named on this consent form.

(please circle one above)

Name ______________________ APC number ____________

Signature ______________________ Date ___ / ___ / _____ (DD MM YYYY)

For prescription requirements please see the relevant Policy Statement.

Information for Vaccinator

Details confirmed ☐ Positive answer to any screening questions? Yes ☐ No ☐

Record information and advice given:

Informed consent obtained? Yes ☐ No ☐ Date ___ / ___ / _____ (DD MM YYYY) Time ________

Vaccine							**Diluent**		Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
AstraZeneca			0.5mL						
Novavax			0.5mL						

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2* ☐ For those eligible 16 years and above
AstraZeneca	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Dose 3* ☐ 18 years and above	Booster* ☐ 18 years and above	
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Booster ☐ 18 years and above		

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label.

Vaccinator information

Name ______________________

Signature ______________________

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ______________________

Departure time ____________

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.

Released under the Official Information Act 1982

COVID-19 vaccination **consent form**

Person

Surname ______________________ First name ______________________

Phone ________________ Date of birth ___ / ___ / _____ (DD MM YYYY) Age _____ years

Address ____

Medical Centre/GP ______________________________ NHI ____________

Please let the vaccinator know:

- If you are unwell
- If you are pregnant or breastfeeding
- 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 are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years you will get the paediatric dose
- If you have had myocarditis or pericarditis after a vaccination in the past

If you are receiving Novavax, please let your vaccinator know:

- If you are aged under 18 years

If you are receiving AstraZeneca, please let your vaccinator know:

- If you are aged under 18 years
- If you've ever had a major clot or low blood platelets in the past, or have an autoimmune condition that means you are more likely to have a clot
- If you've ever had capillary leak syndrome, a rare condition causing fluid leakage from small blood vessels

- [ ] 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 understand the benefits and risks of COVID-19 vaccination.
- [ ] I understand I will need 2 doses of the COVID-19 vaccine to be fully vaccinated.
- [ ] I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.
- [ ] I understand the side effects associated with this vaccine and know how to get help if needed.

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

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.

Name of parent or legal guardian ______________________ Phone ____________

Relationship to person being vaccinated ______________________

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

Tick the vaccine dose that applies:

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2 ☐ For those eligible 16 years and above
AstraZeneca	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Dose 3* ☐ 18 years and above	Booster* ☐ 18 years and above	
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Booster ☐ 18 years and above	Booster 2 ☐ For those eligible 18 years and above	

I understand that I am receiving a vaccine as indicated above and understand the information given to me.
I agree to receive the vaccine indicated above.

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label. **For any off-label use of a vaccine a prescription is required.**

Released under the Official Information Act 1982

Authorised prescriber (incl. medical practitioner, nurse practitioner or pharmacy prescriber)

I confirm that I have explained the reasons for, the risks and benefits of the **Pfizer**, **AstraZeneca** or **Novavax** vaccination to the person named on this consent form.

(please circle one above)

Name ______________________ APC number ____________

Signature ______________________ Date ___ / ___ / _____ (DD MM YYYY)

For prescription requirements please see the relevant Policy Statement.

Information for Vaccinator

Details confirmed ☐ Positive answer to any screening questions? Yes ☐ No ☐

Record information and advice given:

Informed consent obtained? Yes ☐ No ☐ Date ___ / ___ / _____ (DD MM YYYY) Time ________

Vaccine							Diluent		Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
AstraZeneca			0.5mL						
Novavax			0.5mL						

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2 ☐ For those eligible 16 years and above
AstraZeneca	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Dose 3* ☐ 18 years and above	Booster* ☐ 18 years and above	
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Booster ☐ 18 years and above	Booster 2 ☐ For those eligible 18 years and above	

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label.

Vaccinator information

Name ______________________

Signature ______________________

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ______________________

Departure time ____________

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.

Released under the Official Information Act 1982

COVID-19 vaccination **consent form**

Person

Surname ______________ First name ______________

Phone ______________ Date of birth ___ / ___ / _____ (DD MM YYYY) Age _____ years

Address ______________

Medical Centre/GP ______________ NHI ______________

If you are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years you will get the paediatric dose
- If you have had myocarditis or pericarditis after a vaccination in the past

If you are receiving Novavax, please let your vaccinator know:

- If you are aged under 18 years

Please let the vaccinator know:

- If you are unwell
- If you are pregnant or breastfeeding
- 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

☐ 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 understand the benefits and risks of COVID-19 vaccination.

☐ I understand I will need 2 doses of the COVID-19 vaccine to be fully vaccinated.

☐ I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.

☐ I understand the side effects associated with this vaccine and know how to get help if needed.

Signature ______________ Date ___ / ___ / _____ (DD MM YYYY)

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.

Name of parent or legal guardian ______________ Phone ______________

Relationship to person being vaccinated ______________

Signature ______________ Date ___ / ___ / _____ (DD MM YYYY)

Tick the vaccine dose that applies:

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2 ☐ For those eligible 16 years and above
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Booster ☐ 18 years and above	Booster 2 ☐ For those eligible 18 years and above	

I understand that I am receiving a vaccine as indicated above and understand the information given to me. I agree to receive the vaccine indicated above.

Signature ______________ Date ___ / ___ / _____ (DD MM YYYY)

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label. **For any off-label use of a vaccine a prescription is required.**

Released under the Official Information Act 1982

Authorised prescriber (incl. medical practitioner, nurse practitioner or pharmacy 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. (please circle one above)

Name ______________________ APC number ____________

Signature ______________________ Date ___ / ___ / _____ (DD MM YYYY)

For prescription requirements please see the relevant Policy Statement.

Information for Vaccinator

Details confirmed ☐ Positive answer to any screening questions? Yes ☐ No ☐

Record information and advice given:

Informed consent obtained? Yes ☐ No ☐ Date ___ / ___ / _____ (DD MM YYYY) Time ________

Vaccine							Diluent		Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
Novavax			0.5mL						

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2 ☐ For those eligible 16 years and above
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Booster ☐ 18 years and above	Booster 2 ☐ For those eligible 18 years and above	

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label.

Vaccinator information

Name ______________________

Signature ______________________

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ______________________

Departure time ____________

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.

Released under the Official Information Act 1982

COVID-19 vaccination **consent form**

Person

Surname ______________________ First name ______________________

Phone ______________________ Date of birth ___ / ___ / _____ (DD MM YYYY) Age _____ years

Address ____

Medical Centre/GP ______________________________ NHI ______________

Please let the vaccinator know:

- If you have had myocarditis or pericarditis in the past
- If you are unwell
- 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 are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years you will get the paediatric dose

If you are receiving Novavax, please let your vaccinator know:

- If you are aged under 18 years

Released under the Official Information Act 1982

- ☐ 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 understand the benefits and risks of COVID-19 vaccination.
- ☐ I understand I will need 2 doses of the COVID-19 vaccine to be fully vaccinated.
- ☐ I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.
- ☐ I understand the side effects associated with this vaccine and know how to get help if needed.

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

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.

Name of parent or legal guardian ______________________ Phone ______________

Relationship to person being vaccinated ______________________

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

Tick the vaccine dose that applies:

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2 ☐ For those eligible 16 years and above
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Booster ☐ 18 years and above	Booster 2 ☐ For those eligible 18 years and above	

I understand that I am receiving a vaccine as indicated above and understand the information given to me. I agree to receive the vaccine indicated above.

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label. **For any off-label use of a vaccine a prescription is required.**

Authorised prescriber (incl. medical practitioner, nurse practitioner or pharmacy 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. (please circle one above)

Name ______________________ APC number ____________

Signature ______________________ Date ___ / ___ / ______ (DD MM YYYY)

For prescription requirements please see the relevant Policy Statement.

Information for Vaccinator

Details confirmed ☐ Positive answer to any screening questions? Yes ☐ No ☐

Record information and advice given:

Informed consent obtained? Yes ☐ No ☐ Date ___ / ___ / ______ (DD MM YYYY) Time ________

Vaccine							**Diluent**		Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
Novavax			0.5mL						

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2 ☐ For those eligible 16 years and above
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Booster ☐ 18 years and above	Booster 2 ☐ For those eligible 18 years and above	

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label.

Vaccinator information

Name ______________________

Signature ______________________

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ______________________

Departure time ____________

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.

Released under the Official Information Act 1982

COVID-19 vaccination **consent form**

Person

Surname ______________________ First name ______________________

Phone ______________________ Date of birth ___ / ___ / _____ (DD MM YYYY) Age _____ years

Address ____

Medical Centre/GP ______________________ NHI ______________

Please let the vaccinator know:

- If you have had myocarditis or pericarditis in the past
- If you are unwell
- 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 are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years you will get the paediatric dose

If you are receiving Novavax, please let your vaccinator know:

- If you are aged under 18 years

☐ 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 understand the benefits and risks of COVID-19 vaccination.

☐ I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.

☐ I understand the side effects associated with this vaccine and know how to get help if needed.

Signature ______________________________

Parent / legal guardian / enduring power of attorney Date ___ / ___ / _____ (DD MM YYYY)

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

Name of parent or legal guardian ______________________________

Relationship to person being vaccinated ______________________ **Phone** ______________

Signature ______________________________ **Date** ___ / ___ / _____ (DD MM YYYY)

Tick the vaccine dose that applies:

Paediatric Pfizer	Dose 1 5-11 years ☐	Dose 2 5-11 years ☐	Dose 3* 5-11 years ☐		
Pfizer	Dose 1 12 years and above ☐	Dose 2 12 years and above ☐	Dose 3* 12 years and above ☐	Booster 1 16 years and above ☐	Booster 2 For those eligible 16 years and above ☐
Novavax	Dose 1 18 years and above ☐	Dose 2** 18 years and above ☐	Booster 18 years and above ☐	Booster 2 For those eligible 18 years and above ☐	

I understand that I am receiving a vaccine as indicated above and understand the information given to me. I agree to receive the vaccine indicated above.

Signature ______________________________ Date ___ / ___ / _____ (DD MM YYYY)

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label. **For any off-label use of a vaccine a prescription is required.**

Released under the Official Information Act 1982

Authorised 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. (please circle one above)

Name ______________________ APC number ____________

Signature ______________________ Date ___ / ___ / _____ (DD MM YYYY)

For prescription requirements please see the relevant Policy Statement.

Information for Vaccinator

Details confirmed ☐ Positive answer to any screening questions? Yes ☐ No ☐

If yes, record information and advice given: ______________________

Informed consent obtained? Yes ☐ No ☐ Date ___ / ___ / _____ (DD MM YYYY) Time __________

Vaccine							**Diluent**		Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
Novavax			0.5mL						

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2 ☐ For those eligible 16 years and above
Novavax	Dose 1 ☐ 18 years and above	Dose 2** ☐ 18 years and above	Booster ☐ 18 years and above	Booster 2 ☐ For those eligible 18 years and above	

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label.

Vaccinator information

Name ______________________

Signature ______________________

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ______________________

Departure time __________

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.

Released under the Official Information Act 1982

COVID-19 vaccination **consent form**

Person

Surname ______________________ First name ______________________

Phone ______________________ Date of birth ___ / ___ / _____ (DD MM YYYY) Age _____ years

Address ______________________

Medical Centre/GP ______________________ NHI ______________________

Please let the vaccinator know:

- If you have had myocarditis or pericarditis after a vaccination in the past
- If you are pregnant or breastfeeding
- If you have diabetes
- If you are unwell
- 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 are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years you will get the paediatric dose

If you are receiving Novavax, please let your vaccinator know:

- If your first dose was Pfizer

☐ 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 understand the benefits and risks of COVID-19 vaccination.

☐ I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.

☐ I understand the side effects associated with this vaccine and know how to get help if needed.

Signature ______________________ Date ___ / ___ / _____ (DD MM YYYY)

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.

Name of parent or legal guardian ______________________

Relationship to person being vaccinated ______________________ Phone ______________________

Signature ______________________ Date ___ / ___ / _____ (DD MM YYYY)

Tick the vaccine dose that applies:

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2 ☐ For those eligible 16 years and above
Novavax	Dose 1 ☐ 12 years and above	Dose 2** ☐ 12 years and above	Booster ☐ 18 years and above	Booster 2 ☐ For those eligible 18 years and above	

I understand that I am receiving a vaccine as indicated above and understand the information given to me. I agree to receive the vaccine indicated above.

Signature ______________________ Date ___ / ___ / _____ (DD MM YYYY)

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label. **For any off-label use of a vaccine a prescription is required.**

Released under the Official Information Act 1982

Authorised 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. (please circle one above)

Name ________________________ APC number ____________

Signature ________________________ Date ___ / ___ / ____ (DD MM YYYY)

For prescription requirements please see the relevant Policy Statement.

Information for Vaccinator

Details confirmed ☐ Positive answer to any screening questions? Yes ☐ No ☐

If yes, record information and advice given: ________________________

Informed consent obtained? Yes ☐ No ☐ Date ___ / ___ / ____ (DD MM YYYY) Time ________

Vaccine							**Diluent**		Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
Novavax			0.5mL						

Paediatric Pfizer	Dose 1 5-11 years ☐	Dose 2 5-11 years ☐	Dose 3* 5-11 years ☐		
Pfizer	Dose 1 12 years and above ☐	Dose 2 12 years and above ☐	Dose 3* 12 years and above ☐	Booster 1 16 years and above ☐	Booster 2 For those eligible 16 years and above ☐
Novavax	Dose 1 12 years and above ☐	Dose 2** 12 years and above ☐	Booster 18 years and above ☐	Booster 2 For those eligible 18 years and above ☐	

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label.

Vaccinator information

Name ________________________

Signature ________________________

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ________________________

Departure time ____________

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.

Released under the Official Information Act 1982

COVID-19 vaccination **consent form**

Person

Surname ______________________ First name ______________________

Phone ______________________ Date of birth ___ / ___ / _____ (DD MM YYYY) Age _____ years

Address ____

Medical Centre/GP ______________________________ NHI ____________

Please let the vaccinator know:

- If you have had myocarditis or pericarditis after a vaccination in the past
- If you are pregnant or breastfeeding
- If you have diabetes
- If you are unwell
- 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 are receiving Pfizer, please let your vaccinator know:

- If you are aged under 12 years (you will get the paediatric dose)

If you are receiving Novavax, please let your vaccinator know:

- If your first dose was not Novavax

☐ 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 understand the benefits and risks of COVID-19 vaccination.
☐ I have been told how to seek assistance if I experience symptoms that may be vaccine side effects.
☐ I understand the side effects associated with this vaccine and know how to get help if needed.

Signature ______________________ Date ___ / ___ / _____ (DD MM YYYY)

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.

Name of parent or legal guardian ______________________

Relationship to person being vaccinated ______________________ Phone ______________

Signature ______________________ Date ___ / ___ / _____ (DD MM YYYY)

Tick the vaccine dose that applies:

Paediatric Pfizer	Dose 1 5-11 years ☐	Dose 2 5-11 years ☐	Dose 3* 5-11 years ☐		
Pfizer	Dose 1 12 years and above ☐	Dose 2 12 years and above ☐	Dose 3* 12 years and above ☐	Booster 1 16 years and above ☐	Booster 2 For those eligible 16 years and above ☐
Novavax	Dose 1 12 years and above ☐	Dose 2** 12 years and above ☐	Booster 18 years and above ☐	Booster 2 For those eligible 18 years and above ☐	

I understand that I am receiving a vaccine as indicated above and understand the information given to me. I agree to receive the vaccine indicated above.

Signature ______________________ Date ___ / ___ / _____ (DD MM YYYY)

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label. **For any off-label use of a vaccine a prescription is required.**

Released under the Official Information Act 1982

Authorised 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. (please circle one above)

Name ______________________ APC number ____________

Signature ______________________ Date ___ / ___ / ______ (DD MM YYYY)

For prescription requirements please see the relevant Policy Statement.

Information for Vaccinator

Details confirmed ☐ Positive answer to any screening questions? Yes ☐ No ☐

If yes, record information and advice given: ______________________

Informed consent obtained? Yes ☐ No ☐ Date ___ / ___ / ______ (DD MM YYYY) Time ________

Vaccine							Diluent		Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL						
Pfizer/BioNTech			0.3mL						
Novavax			0.5mL						

Paediatric Pfizer	Dose 1 ☐ 5-11 years	Dose 2 ☐ 5-11 years	Dose 3* ☐ 5-11 years		
Pfizer	Dose 1 ☐ 12 years and above	Dose 2 ☐ 12 years and above	Dose 3* ☐ 12 years and above	Booster 1 ☐ 16 years and above	Booster 2 ☐ For those eligible 16 years and above
Novavax	Dose 1 ☐ 12 years and above	Dose 2** ☐ 12 years and above	Booster ☐ 18 years and above	Booster 2 ☐ For those eligible 18 years and above	

* These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine (i.e., a mixed dose schedule) is considered off-label.

Vaccinator information

Name ______________________

Signature ______________________

Post vaccination information given ☐

Observation area information

Details of any AEFI or observations recorded ☐

CARM Report completed ☐

Signature ______________________

Departure time ____________

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.

Released under the Official Information Act 1982

COVID-19 **vaccination consent form**

Person

Surname ________________ First name ________________

Phone ________________ Date of birth ___/___/_____ (DD MM YYYY) Age _____ years

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

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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 ______________________

Te Kāwanatanga o Aotearoa
New Zealand Government

Mā tātau katoa e ārai atu te COVID-19

Te Whatu Ora
Health New Zealand

Released under the Official Information Act 1982

COVID-19 **vaccination consent form**

Person

Surname ______________________ First name ______________________

Phone ______________________ Date of birth ___ / ___ / _____ (DD / MM / YYYY) Age _____ years

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

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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

COVID-19 vaccination primary course				COVID-19 vaccination boosters	
Pfizer Comirnaty (3mcg) 6 months - 4 years	**Pfizer** Comirnaty (10mcg) 5 – 11 years	**Pfizer** Comirnaty (30mcg) 12 years and over	**Novavax** Nuvaxovid 12 years and over	**Pfizer** Comirnaty (15/15mcg) Original/ Omicron BA.4/5 16+ years for those eligible	**Novavax** Nuvaxovid 16+ years for those eligible
Dose 1 ☐	Dose 1 ☐	Dose 1 ☐	Dose 1 ☐	Dose 1 ☐	Dose 1 ☐
Dose 2 ☐	Dose 2 ☐	Dose 2 ☐	Dose 2** ☐	Dose 2 ☐	Dose 2 ☐
Dose 3 ☐	Dose 3* ☐	Dose 3* ☐	Dose 3* ☐		

* 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 (Comirnaty 3mcg and 10mcg 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 ______________________

Te Kāwanatanga o Aotearoa
New Zealand Government

Mā tātau katoa e ārai atu te COVID-19

Te Whatu Ora
Health New Zealand

Released under the Official Information Act 1982

COVID-19 **vaccination consent form**

Person

Surname ______________________ First name ______________________

Phone ______________________ Date of birth ___ / ___ / _____ (DD / MM / YYYY) Age _____ years

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 confirm that I/ the person being vaccinated have not tested positive for COVID-19 in the last 6 months.
- ☐ 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

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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

Confirmed consumer has not tested positive for COVID-19 in the last 6 months ☐

CIR checked to ensure recommended dose interval before administration ☐

COVID-19 vaccination primary course				COVID-19 vaccination additional dose	
Pfizer Comirnaty (3mcg) 6 months - 4 years	**Pfizer** Comirnaty (10mcg) 5 – 11 years	**Pfizer** Comirnaty (30mcg) 12 years and over	**Novavax** Nuvaxovid 12 years and over	**Pfizer** Comirnaty (15/15mcg) Original/ Omicron BA.4/5 16+ years for those eligible‡	**Novavax** Nuvaxovid 18+ years for those eligible
Dose 1 ☐	Dose 1 ☐	Dose 1 ☐	Dose 1 ☐	Dose ____ ☐	Dose ____ ☐
Dose 2 ☐	Dose 2 ☐	Dose 2 ☐	Dose 2† ☐		
Dose 3 ☐	Dose 3* ☐	Dose 3* ☐	Dose 3* ☐		

* 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.
‡ Those 12-15 years that meet severely immunocompromised criteria are recommended for an additional dose. This will require a prescription.

Vaccine details							Diluent (Comirnaty 3mcg and 10mcg 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 ______________________

Te Kāwanatanga o Aotearoa
New Zealand Government

Mā tātau katoa e ārai atu te COVID-19

Te Whatu Ora
Health New Zealand

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