

COVID-19 vaccination

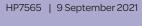
consent form

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 / /

New Zealand Government









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CARM Report completed

Details of any AEFI or observations recorded



Departure time _







Surname _____ First name _____ _____ 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. Date _ Signature _ 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. _____ Relationship to patient _____ Name of parent or guardian Signature _ Third primary dose I understand I am receiving a third primary dose to provide increased protection against COVID-19. Date ___ / ___ / ___ Signature **Medical practitioner** I confirm I have explained the reasons for, the risks and outcomes of a third primary vaccination to the consumer named above. Date ___ / ___ / ___ Signature _ PLEASE NOTE: A prescription from a medical practitioner is required for a third primary dose. Te Kāwanatanga o Aotearoa MINISTRY OF

New Zealand Government





HP7565 | COVID-19 vaccine consent form general | 22 Oct 2021



Patient

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Information for	·Vaccinato	or							
Details confirme	ed 🗌								
Positive answert	to any scree	ening que	stions?	Yes 📗 1	No 🗌				
Record informat	ion and adv	vice given	:						
Informed conser	nt obtained	l? Yes	No [
Date/	_ /	Time _						3	O
If deferred, decli	ned or not i	medical fi	t for vac	cine recor	d detail _	*	<u>(),</u>		7
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 Dose 3									
Post vaccinatio	n informat	tion divo			Cignotum	o of vocal	nator		
Post vaccinatio	ii iiii Oriiia	Liongive							
	16		6.0		rvame or	vaccinati	or		
Observation ar	ea informa	ation			Signatur	0			
Details of any AE	Florobser	vations re	ecorded						
CARM Report co	mpleted [Departui	re time _			
Vaccination si									
If administering	g a third prii	mary dos	e, this sh	ould be sig	gned belov	w by the c	iinical leac	1.	
Name				_		, .			
Signature				[Date	. / / _			

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Te Kāwanatanga o Aotearoa New Zealand Government

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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.

Patient

Surname	First r	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 Pfiz please let your vaccinate. If you are aged under 12. If you have had myocal pericarditis after a vaccin the past	tor know: 2 years rditis or	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 about the COVID-19 I have been informed of the cont I have had a chance to ask quest I believe I understand the benefit I understand it is my choice to get I understand I will need 2 doses of Signature	vaccine. craindications of the Co ions and they were ans ts and risks of COVID-1 et the COVID-19 vaccina	DVID-19 vaccination ation.	ne. satisfaction.
	⟨O⟩		
Parent / guardian / enduring portion of parent, guardian or enduring patient named above. Name of parent or guardian Relationship to patient Signature	uring power of attorney	, and agree to	the COVID-19 vaccination of the Date / /
Tick the vaccine dose that app	lies:		
Pfizer Dose 1 Dose 2 Dose 3	Booster		Dose 2" Dose 3" Booster" derstand 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.

Medical pract	itioner								
I confirm that I	•					comes of			Zeneca
vaccination to	the patient	named c	n this co	onsent fo	rm.		(please o	circle one)	//
Signature							<u> </u>	Date _	
PLEASE NOTE: A recommended for									
Information for \	/accinato	r							
Details confirmed	H 🗌		Positiv	/e answe	r to any scre	ening qu	estions? Ye	s N	0
Record information	on and adv	ice given:							0
Informed consen	t obtained'	? Yes	No _	D	ate/_	/	. Time		Θ
If deferred, declin	ed or not n	nedically 1	fit for vac	ccine, rec	ord 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	\		(0)			
Pfizer	Dose:	O* D.	poster		AstraZen	_	Dose 3*	¬	end 🗔
*These doses are cor *AstraZeneca as a se	ഥ nsidered off-la	abel use.	5	n-AstraZen	Dose 1 eca dose is co	Dose 2**		Boos	itei []
Vaccinator inf	ormation	0	Ś	0	Observ	ation are	ea informat	tion	
Name			-		Details	of any AE	FI or observ	ations re	corded
Signature				<u> </u>	CARMR	Report co	mpleted		
Post vaccinatio	n informat	tion given			Signatu	ire			
					Depart	ure time		_	
Vaccination	site clinica	llead							
If administering AstraZeneca as dose 1), this sho	the second	ary dose o	fthe prin	nary cours					
Name									
Signature							D	ate	_//
When a pres			rescriber	must reta	in this form c	or a copy, a	and hold secu	ırely as a ı	medical record





Person					
Surname		First nam	e		
Phone	Date o	of birth /	/	Age _	years
ddress					
edical Centre/GP				NHI	
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 sever allergic reaction to any vaccin or injection in the past	 please let your v If you are aged you will get the If you have had pericarditis aft in the past 	vaccinator kno I under 12 years e paediatric dose	If you rare o	re receiving Astra et your vaccinat are aged under 18 are pregnant ve ever had a maj past, or have an a s you are more lik ve ever had capill ondition causing 1 vessels	or know: years or clot or low utoimmune ely to have a ary leak sync
I have read the COVID me information about	•		r have had	explained to	
I have had a chance to	ask questions and	d they were an	swered to r	ny satisfaction.	
	the benefits and ri	isks of COVID-	19 vacc <mark>i</mark> nat	ion.	
	d 2 doses of the Co	OVID-19 vaccir	ne to be full	y vaccinated.	
] I have been told how t	o seek assist <mark>anc</mark> e i	if I experience	symptoms	that may be va	ccine side e
I understand the side	effects a <mark>ssoci</mark> ated	l with this vacc	ine and kno	ow how to get he	elp if neede
Signature	7				oate /
	(2)				,
Parent / legal guardian /	enduring power c	ofattorney			
am the parent, legal guard person named above.	dian or enduring po	ower of attorne	ey, and agre	e to the COVID	-19 vaccina
Name of parent or legal gu	ardian				
Relationship to person bei					
Signature					oate/
Tick the vaccine dose that	at applies:				
Paediatric Pfizer	Pose 1	Dose 2 5-12 years			
Pfizer	Pose 1	Dose 2 12 years and above		se 3*	Booster 18 years and
AstraZeneca	Pose 1 By years and above	Dose 2** 18 years and above	Dos	se 3 [*] ears and above	Booster*
I understand that I am rec	_		ove and und		
Signature					oate /

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

Authorised pr	escriber ((incl. med	dical pra	actitioner	r, nurse pr	actitione	er or phar	macy pre	escriber)
I confirm that I vaccination to	•					tcomes of		r or Astra se circle one)	
Signature								Date	//
PLEASE NOTE: A recommended for									
nformation for N		r	Positi	vo answor	to any scr	ooning au	ostions?	Voc 🗆 🗈	No 🗍
Record information		rice given:		ve al iswei	to arry scr	eeriirig qu	estions:	162 1	10
	orraina aav	100 8110111							
nformed consen	t obtained	? Yes 🗌	No _] Da	nte/	/	_ Tim	ne	O'O'
Vaccine						\	Diluent		Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer			0.2mL			0			
Pfizer/BioNTech			0.3mL						
AstraZeneca			0.5mL						
Paediatric Pfize	r Dos	se 1 years		Dose 2 5-12 years	D				
Pfizer	Dos	se 1 ears and above		Dose 2 12 years and a	hove	Dose 3*	ahove	Booster 18 years and	dahove
AstraZeneca	Dos			Dose 2** 18 years and a		Dose 3*	П	Booster*	
These doses are cor * AstraZeneca as a se	nsidered off-l	abel use.						,	
Vaccinator inf	formation	0	\$	(0)	Obser	vation ar	ea inform	nation	
Name	76				Details	of any AE	FI or obse	ervations r	ecorded
Signature					CARM	Report co	mpleted		
Post vaccination	on informat	tion given			Signat	ure			
					Depar	ture time			
(112								
Vaccination s If administering			as a thir	darimanyd	oco Actro7	onoca vac	oino as a bo	octor doc	. ∩P
AstraZeneca as dose 1), this sho	the second	dary dose c	fthe prir	mary cours					
Name									
Signature								Date	_//
When a pres			rescribe	r must retai	in this form	or a copy, a	and hold se	ecurely as a	medical record





Person				
Surname		First name		
Phone	Date of	of birth / /	Age	years
Address				
Medical Centre/GP			NHI	
Please let the vaccinator ke 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 sea allergic reaction to any vacor injection in the past	please let y If you are a you will ge If you have pericardit in the pass vere lif you are replease let y	eceiving Pfizer, your vaccinator know: aged under 12 years at the paediatric dose had myocarditis or is after a vaccination t eceiving Novavax, your vaccinator know: aged under 18 years	blood platelets in autoimmune cor are more likely to • If you've ever had syndrome, a rare	nder 18 years d a major clot or low the past, or have an addition that means you whave a clot
me information ab I have had a chanc I understand the be I understand I will r I have been told ho	uardian or enduring po	d they were answered ovidential vaccine to be ovidential with this vaccine and of attorney	e fully vaccinated. coms that may be vac d know how to get he Da I agree to the COVID-	Ip if needed. ate / / 19 vaccination of the
0.8.10.00.0	-/0			
Tick the vaccine dose				
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 I I agree to receive the va	•		d understand the info	rmation given to me.
Signature			D	ate / /

^{*} 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 por I confirm that I Pfizer, AstraZ (please circle one al	have expl Zeneca or	ained the	reasons f	or, the ris	ks and out	comes of	the		scriber)
Name							APC nun	nber		
Signature							1	Date	_/	/
For prescriptio	n requirem	ents pleas	e see the	relevant P	olicy State	ment.				
Information for	Vaccinato	or								
Details confirmed	d 🗌		Positiv	e answer	to any scre	ening qu	estions? Y	∕es	lo 🗌	
Record information	on and ad	vice given:								
Informed consen	it obtained	d? Yes 🗌	No 🗌	Da	te/_	/	. Tim	e		b
Vaccine							Diluent		Pfizer or	hly
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconsti	
Paediatric Pfizer			0.2mL							
Pfizer/BioNTech			0.3mL							
AstraZeneca			0.5mL							
Novavax			0.5mL							
Paediatric Pfiz	zer	Dose 1 5-12 years		Dose 2 5-12 years						
Pfizer		Dose 1 12 years and ab	ove D	Dose 2 12 years an	d above	Dose 3	and above	Booste 18 years	er and above	
AstraZeneca		Dose 1 18 years and ab	oove 🗌	Dose 2** 18 years an	d above	Dose 3	and above	Booste 18 years	er* and above	
Novavax		Dose 1 18 years and ab	oove 🔲	Dose 2** 18 years an	nd above					
* These doses are consid	dered off-labe	l use. ** A seco	nd primary o	lose following	another COVII	D-19 vaccine	(i.e., a mixed d	ose schedule)) is conside	red off-label
Vaccinator in	formatio	n			Obsei	vation a	rea inforn	nation		
Name	*					•	EFI or obse		recorde	ed 🗌
Signature	→ C					·	ompleted			
Post vaccinati	on inform	ation giver	n 🗍							
					Бераг	ture time	ə	_		
Vaccination s If administering			hould be s	signed belo	ow by the cli	nical lead.				
Name										
Signature								Date	_/	/
When a pres							/,			





Phone Address Medical Centre/GP 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 me information about I have had a chance to I understand the bene I understand I will nee I have been told how to I understand the side Signature Parent / legal guardian / I am the parent, legal guard person named above.	If you are please lee If you a you will If you he pericar in the pericar in the pericas If you are please lee	re receiving Pfizet your vaccinate aged under 12 ll get the paediatre have had myocar roitis after a vaccinate receiving Novet your vaccinate aged under 18 n provided, and vaccine. and they were f COVID-19 vaccine if I experient	er, tor know: tyears ric dose ditis or sination avax, tor know: tyears d/or have answere ccination ccine to b	If you a please If you blood autoin are m If you syndrafluid I The had explainted to my sation of fully vaccutoms that n	elet your vacuare aged under aged under aged under aged under aged under aged under aged aged aged aged aged aged aged aged	g AstraZeneca, ccinator know: der 18 years la major clot or low the past, or have an dition that means you have a clot l capillary leak condition causing n small blood vessels cine side effects. lp if needed.
Medical Centre/GP Please let the vaccinator known of If you are unwell of If you are pregnant or breastfeeding of If you're on blood-thinning medications or have a bleeding disorder or If you've had a previous severe allergic reaction to any vaccine or injection in the past I have read the COVID me information about the land a chance to lander the	If you are please lee If you a you will If you he pericar in the pericar in the pericas If you are please lee	re receiving Pfizet your vaccinate aged under 12 Il get the paediatrave had myocar rditis after a vaccioast re receiving Novet your vaccinate aged under 18 in provided, and vaccine. and they were f COVID-19 vaccine if I experient	er, tor know: tyears ric dose ditis or sination avax, tor know: tyears d/or have answere ccination ccine to b	If you a please If you blood autoin are m If you syndrafluid I The had explainted to my sation of fully vaccutoms that n	are receiving let your vacuate aged under aged under aged under aged under aged under aged to a receive a rare aged to a rare aged from a rare	g AstraZeneca, ccinator know: Ider 18 years I a major clot or low the past, or have an Idition that means you have a clot I capillary leak condition causing a small blood vessels cine side effects. Ip if needed.
Please let the vaccinator known of If you are unwell of If you are pregnant or breastfeeding of If you're on blood-thinning medications or have a bleeding disorder of If you've had a previous severe allergic reaction to any vaccine or injection in the past of I have read the COVID me information about the I understand I will nee I have been told how the I understand the side of I understand the side of I understand I will nee I have been told how the I understand I will nee I have been told how the I understand I will nee I have been told how the I understand I will nee I have been told how the I understand I will nee I have been told how the I understand I will nee I have been told how the I understand I will nee I	If you are please leed. If you are you will or lif you are please leed. If you are please leed	re receiving Pfizet your vaccinate aged under 12 ll get the paediatre have had myocar roitis after a vaccinate receiving Novet your vaccinate aged under 18 n provided, and vaccine. and they were f COVID-19 vaccine if I experient	er, tor know: years ric dose ditis or sination avax, tor know: years d/or have answere answere coination	If you a please If you blood autoin are m If you syndrifluid I had explained to my sation of fully vaccitoms that n	are receiving let your vacuate aged under aged under aged under aged under aged under aged to a receive a rare aged to a rare aged from a rare	g AstraZeneca, ccinator know: Ider 18 years I a major clot or low the past, or have an Idition that means you have a clot I capillary leak condition causing a small blood vessels cine side effects. Ip if needed.
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 me information about I have had a chance to I understand the benefit of the past I have been told how to the land of the side Signature Parent / legal guardian / I am the parent, legal guardian	please le lifyou a you will lifyou h pericar in the p lifyou ar please le lifyou a lifyou a please le lifyou a de a self and risks of d 2 doses of the o seek assistance effects associate	et your vaccinate are aged under 12 ll get the paediation ave had myocar rditis after a vaccioast re receiving Novet your vaccinate aged under 18 n provided, and vaccine. and they were f COVID-19 vaccine if I experient	tor know: I years ric dose ditis or sination avax, tor know: I years d/or have answere acination ccine to bace symp	please If you If you blood autoir are m If you syndr fluid I had explain d to my sati	elet your vacuare aged under aged under aged under aged under aged under aged under aged aged aged aged aged aged aged aged	der 18 years I a major clot or low the past, or have an Idition that means you have a clot I capillary leak condition causing I small blood vessels cine side effects. Ip if needed.
me information about I have had a chance to I understand the bene I understand I will nee I have been told how t I understand the side Signature Parent / legal guardian / I am the parent, legal guard	the COVID-19 value ask questions and risks of d 2 doses of the o seek assistance associated as a secondary as a	vaccine. and they were fCOVID-19 vac e COVID-19 vac ace if I experien	answere ccination ccine to b	ed to my sati pe fully vacc toms that n	isfaction. sinated. may be vace w to get hel	p if needed.
Name of parent or legal gu Relationship to person bei Signature	dian or enduring ardian ng vaccinated			d agree to th	ne COVID-1 _ Phone -	$\frac{19}{19} / \frac{1}{100} / \frac{1}$
ick the vaccine dose that a		Dose 1		Dose 3*		
Paediatric Pfizer 5-11 year		5-11 years		5-11 years		
Pfizer Dose 1	s and above	Dose 2 12 years and above	ve 🗌	Dose 3* 12 years and a	above	Booster 16 years and above
AstraZeneca Dose 1	s and above	Dose 2** 18 years and above	ve 🗌	Dose 3* 18 years and a	above	Booster* 18 years and above
Novavax Dose 1	s and above	Dose 2** 18 years and above	ve 🗌			
understand that I am receiving agree to receive the vaccine			ve and u	nderstand t	the informa	ation given to me.
gnature					Dat	e//////

Authorised pr I confirm that I Pfizer, AstraZ	have e	expla	ined the re	easons [·]	for, the risk	s and outc	omes of th	ie		ber)
(please circle one ab								APC numbe	er	
Signature								Date/	/	
For prescription	n requ	ireme	ents please	see the	relevant Po	olicy Staten		DD	MM YY	ΥΥ
Information for \	Vaccii	nato	r							
Details confirmed	d 🗌			Positiv	/e answer t	o any scree	ening ques	tions? Yes	No [
Record information	on and	d adv	ice given:							
Informed consen	t obta	ined?	? Yes 🗌	No 🗌	Dat	e/_	M / YYYY	Time		28 N
Vaccine								Diluent		Pfizer only
Name of vaccine	Date		Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution
Paediatric Pfizer				0.2mL		. (2	C		
Pfizer/BioNTech				0.3mL				1		
AstraZeneca				0.5mL		1				
Novavax				0.5mL						
Paediatric Pfize	r	Dose 5-11 ye			Dose 1 5-11 years		Dose 3 * 5-11 years			
Pfizer		Dose 12 year	1 rs and above		Dose 2 12 years and al	bove	Dose 3* 12 years and	above	Booster 16 years an	d above
AstraZeneca			rs and above		Dose 2** 18 years and a	bove	Dose 3* 18 years and	above	Booster* 18 years an	d above
Novavax			1 rs and above		Dose 2** 18 years and a	bove				
* These doses are consid	lered off	f-label (use. ** A secon	d primary	dose following a	another COVID	-19 vaccine (i.e	., a mixed dose s	schedule) is co	onsidered off-label.
Vaccinator in	forma	ation				Observ	vation are	a informat	ion	
Name							· ·	l or observa		orded
Signature			(0)				·	npleted		
Post vaccination	on info	orma	tion given			_				
						Бераг	ure time .		_	
Vaccination s When administed the consumer.				ofvaccin	e, the clinic	al lead signs	as an inforr	med consent	final check	cwith
Name								_		
Signature								_ Dat	e/_	MM /
When a pres						in this form				





Person											
			st name								
Phone		Date of birth _	/////	. Age y	ears						
Address		L	MIMI YYYY								
Medical Centre/G	P			NHI	_						
Please let the vacci If you are unwell If you are pregnant breastfeeding If you're on blood-medications or har bleeding disorder If you've had a preallergic reaction to or injection in the present the second	thinning thinning thinning the a trium severe a trium severe anny vaccine the trium severe	f you are receiving Polease let your vaccin If you are aged under you will get the paedi If you have had myoo pericarditis after a vain the past f you are receiving Nolease let your vaccin If you are aged under	nator know: p 12 years tatric dose carditis or accination ovavax, nator know:	you are receiving Astrilease let your vaccina If you are aged under 18 If you've ever had a may blood platelets in the pautoimmune condition are more likely to have If you've ever had capil syndrome, a rare cond fluid leakage from sma	tor know: By years jor clot or low east, or have an that means you a clot lary leak ition causing						
 □ 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											
Tick the vaccine o	lose 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 I agree to receive th			oove and underst	and the information	given to me.						
Signature				_ Date _	/						
* These doses are consid (i.e., a mixed dose sched				-19 vaccine	MIM YYYY שואי ט						

Authorised pr I confirm that II Novavax vacci	have expla	ained the r	easons fo	or, the risk	s and bene	efits of th	•		_	
(please circle one ab	ove)						APC num	ber		_
Signature							Date	/	/	
For prescription	n requireme	ents please	e see the r	elevant Po	olicy Statem	nent.	DD	IAIIAI	YYYY	
Information for \	/accinato	r								
Details confirmed			Positive	e answer t	o any scree	ening qu	estions? Ye	s	No 🗌	
Record information	n and adv	ice given:								
Informed consent	obtained	? Yes 🗌	No 🗌	Dat	e/_	M /	Time)	0,6	
Vaccine							Diluen	t	Pfizeronl	ly
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expir	y Time of reconstitu	ution
Paediatric Pfizer			0.2mL			2				
Pfizer/BioNTech			0.3mL							
AstraZeneca			0.5mL							
Novavax			0.5mL							
Paediatric Pfizer	Dose 1 5-11 years		Dose 2 5-11 years	0.0	Dose 3* 5-11 years					
Pfizer	Dose 1 12 years an	d above	Dose 2 12 years and	d above	Dose 3* 12 years and a	above	Booster 1 16 years and ab	oove	Booster 2* For those eligible 16 years and above	
AstraZeneca	Dose 1 18 years an	d above	Dose 2** 18 years and		Dose 3* 18 years and a	above	Booster* 18 years and ab	oove		
Novavax	Dose 1 18 years ar	nd above	Dose 2** 18 years an							
* These doses are consid	ered off-label	use. ** A secor	nd primary do	ose following a	another COVID	-19 vaccine	(i.e., a mixed dos	e schedu	le) is considered o	ff-label.
Vaccinator in	formation				Observ	vation a	rea inform	ation		
Name			•			•			s recorded [
Signature		10				·	completed [_		
Post vaccination	on informa	tion given			•					
r oot vacon late.		1011 811 011			Depart	ture tim	e			
Vaccination si When administe the consumer.			ofvaccine	, the clinica	al lead signs	as an inf	ormed conse	nt final	check with	
Name										
Signature							D	ate _	D / MM / Y	YYY
When a pres	cription is u	used, the p	rescriber	must retai	n this form	or a cop	у,			

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Person		F.			
			st name		
		Date of birth _	DD / MM / YYYY	Age	years
Medical Centre/G	P			NHI	
 Please let the vacci If you are unwell If you are pregnant breastfeeding If you're on blood-tending disorder If you've had a prevallergic reaction to or injection in the present and the present	thinning vious severe any vaccine	f you are receiving Prolease let your vaccing If you are aged under you will get the paedi If you have had myoo pericarditis after a vain the past f you are receiving Nolease let your vaccing If you are aged under	nator know: p 12 years atric dose carditis or accination ovavax, nator know:	Fyou are receiving As lease let your vaccir If you are aged under If you've ever had a melood platelets in the autoimmune condition are more likely to have a syndrome, a rare confluid leakage from sm	nator know: 18 years najor clot or low past, or have an on that means you re a clot oillary leak ndition causing
me informa I have had a I understand I understand I have been	tion about the CO\ chance to ask que d the benefits and d I will need 2 dose told how to seek as	mation provided, a VID-19 vaccine. estions and they we risks of COVID-19 v s of the COVID-19 v essistance if I experie	re answered to maccination. raccine to be fully ence symptoms t	y satisfaction. vaccinated. that may be vaccing whow to get help if	
I am the parent, person named a Name of parent	legal guardian or er		•	Phone	raccination of the
Tick the vaccine d	ose that applies:				
Paediatric Pfizer	Dose 1	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 all agree to receive the			oove and underst		
* These doses are consider	dered off-label use. ** A	second primary dose fo	llowing another COVID	Date _ 0-19 vaccine	DD / MM / YYYY
		bel For any off-label us			

Authorised pro I confirm that I I Novavax vacci	have expla	ined the r	easons fo	or, the risk	s and bene	fits of th	•	• •	•	
(please circle one about the second of the s							APC numl	oer		_
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Information for \	/accinato	r								
Details confirmed			Positive	e answer t	o any scree	ening qu	estions? Ye	s	No 🗌	
Record information	on and adv	ice given:								
Informed consent	obtained	? Yes 🗌	No 🗌	Dat	e/_	M /	Time			
Vaccine							Diluent	t	Pfizeronl	У
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitu	ution
Paediatric Pfizer			0.2mL							
Pfizer/BioNTech			0.3mL							
AstraZeneca			0.5mL		7					
Novavax			0.5mL							
Paediatric Pfizer	Dose 1 5-11 years		Dose 2 5-11 years	0.0	Dose 3* 5-11 years					
Pfizer	Dose 1 12 years and	d above	Dose 2 12 years and	d above	Dose 3* 12 years and a	bove	Booster 1 16 years and ab	ove	Booster 2* For those eligible 16 years and above	
AstraZeneca	Dose 1 18 years an	d above	Dose 2** 18 years and	d above	Dose 3* 18 years and a	bove	Booster* 18 years and ab	ove		
Novavax	Dose 1 18 years an		Dose 2** 18 years an							
* These doses are consider	ered off-label	use. ** A secor	nd pr <mark>imar</mark> y do	ose following a	another COVID-	-19 vaccine	(i.e., a mixed dos	e schedul	e) is considered o	ff-label.
Vaccinator in	formation						rea informa			_
Name			•			•	、EFI or obser completed [_	recorded _	
Signature		CO				·				
Post vaccination	on informa	tion given			_		e			
Vaccination si When administe the consumer.			ofvaccine	e, the clinica	al lead signs	as an inf	ormed conse	nt final (check with	
Name										
Signature							D	ate	O / MM / Y	YYY
When a pres	cription is u	used, the p	rescriber	must retai	n this form	or a cop	у,			

Te Kāwanatanga o Aotearoa New Zealand Government

Unite against



Person					
Surname			st name		
Phone		Date of birth _	<u>//</u>	Age	years
Address		L	יארא ואואו טע YYY	Y	
Medical Centre/GF	P			NHI	
Please let the vaccin If you are unwell If you are pregnant breastfeeding If you're on blood-t medications or have bleeding disorder If you've had a prevallergic reaction to or injection in the p	or	f you are receiving Problease let your vaccin If you are aged under you will get the paedi If you have had myoo pericarditis after a vain the past f you are receiving Noblease let your vaccin If you are aged under	nator know: 12 years fatric dose carditis or accination ovavax, nator know:	blood platelets i autoimmune co are more likely t • If you've ever ha syndrome, a rar	accinator know: Inder 18 years Ind a major clot or low In the past, or have an Indition that means you Indition that means you
me informat I have had a I understand I understand I have been	tion about the CO\ chance to ask que d the benefits and d I will need 2 dose told how to seek as	mation provided, a VID-19 vaccine. estions and they we risks of COVID-19 vacsistance if I experiessociated with this	re answered to accination. vaccine to be ful	my satisfaction. ly vaccinated. s that may be vacow how to get he	ccine side effects.
I am the parent, I person named a Name of parent	legal guardian or e	10,	-	Phone	-19 vaccination of the
Fick the vaccine d	ose that applies:				אוייו שני אויייו טע
	Dose 1	Dose 2	Dose 3*		
Paediatric Pfizer	5-11 years	5-11 years	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 abo	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 abo	ove
Novavax	Dose 1 18 years and above	Dose 2** 18 years and above	Booster 18 years and above		
understand that I a agree to receive th			oove and under	stand the inform	nation given to me.
Signature				Da	//
		second primary dose fo bel. For any off-label u s		ID-19 vaccine	

Authorised pr I confirm that I Novavax vacci	have explaination to t	ined the r	easons fo	or, the risk	s and bene	efits of tl	· ·	• •	•	
(please circle one ab	-						APC num	ber		_
Signature							Date	//		
For prescription	n requireme	ents please	e see the r	elevant Po	licy Staten	nent.	DD	ММ	YYYY	
Information for \	/accinato	r								
Details confirmed	I 🗌		Positive	e answer t	o any scree	ening qu	estions? Ye	es 🔲 N	lo 🗌	
Record information	on and adv	ice given:								
Informed consent	t obtained	? Yes 🗌	No 🗌	Dat	e/_	M /	Time		8	
Vaccine							Diluen	t	Pfizer onl	У
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitu	ution
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	0.0	Dose 3* 5-11 years					
Pfizer	Dose 1 12 years an	d above	Dose 2 12 years and	d above	Dose 3* 12 years and a	above	Booster 1 16 years and ab	F	Booster 2* For those eligible 6 years and above	
AstraZeneca	Dose 1 18 years an	d above	Dose 2** 18 years and	d above	Dose 3* 18 years and a	above	Booster* 18 years and ab	pove		
Novavax	Dose 1 18 years ar		Dose 2** 18 years an		Booster 18 years and					
* These doses are consid	7		nd primary do	ose following a) is considered o	ff-label.
Vaccinator in	formation						a rea inform AEFI or obsei		recorded [7
Name	•		·	_		•	completed [recorded _	
Signature		10.		_		·				
Post vaccination	on informa	tion given			J		e			
Vaccinations When administer the consumer.			ofvaccine	, the clinica	al lead signs	as an inf	ormed conse	ent final cl	neck with	
Name										
Signature							D	ate	///	YYY
When a pres	cription is (used, the p	rescriber	must retai	n this form	or a cop				

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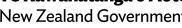




Person					
Surname			st name		
Phone		Date of birth _	$\frac{1}{100}$ $\frac{1}{100}$ $\frac{1}{100}$ $\frac{1}{100}$	Age	years
Address					
Medical Centre/GP				NHI	
 Please let the vaccin If you are unwell If you are pregnant of breastfeeding If you're on blood-the medications or have bleeding disorder If you've had a previous allergic reaction to a or injection in the page 	ninning • e a ous severe any vaccine	f you are receiving Polease let your vaccion If you are aged under you will get the paeding lif you have had myour pericarditis after a varienthe past f you are receiving Noblease let your vaccion If you are aged under	nator know: 12 years fatric dose carditis or accination ovavax, nator know:	autoimmune condare more likely to l If you've ever had syndrome, a rare of	der 18 years a major clot or low the past, or have an dition that means you have a clot capillary leak
me informat I have had a d I understand I understand I have been t	ion about the CO\ chance to ask que I the benefits and I I will need 2 dose old how to seek as	mation provided, a VID-19 vaccine. estions and they we risks of COVID-19 v s of the COVID-19 v ssistance if I experi	re answered to raccination. vaccine to be ful	my satisfaction. ly vaccinated. s that may be vaccon whow to get help	
I am the parent, le person named al Name of parent o	egal guardian or er	10,	-	Phone	9 vaccination of the
ick the vaccine de	se that applies:			L	דדד ויווייו טכ
	Dose 1	Dose 2	Dose 3*		
Paediatric Prizer	5-11 years	5-11 years	5-11 years		
rizer	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	
vovavax	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	
understand that I a agree to receive the		cine as indicated al ed above.	oove and under		tion given to me.
gnature				Date	e /
		second primary dose fo bel. For any off-label u s		ID-19 vaccine	DD MM YYYY

Authorised pr I confirm that I Novavax vacci (please circle one ab	have expla nation to t	ained the r	easons fo	or, the risk	s and bene	fits of th	·	• •	-	
Name	-						APC numb	oer		-
Signature							Date	//		
For prescription	n requireme	ents please	e see the r	elevant Po	olicy Statem	nent.	DD	MM	YYYY	
Information for \	/accinato	r								
Details confirmed			Positive	e answer t	o any scree	ening qu	estions? Ye	s N	lo 🗌	
Record information	on and adv	rice given:								
Informed consent	obtained	? Yes 🗌	No 🗌	Dat	e/_	M /	Time		<u>~</u> %	
Vaccine							Diluent		Pfizeronly	,
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitu	tion
Paediatric Pfizer			0.2mL			2				
Pfizer/BioNTech			0.3mL							
AstraZeneca			0.5mL		~					
Novavax			0.5mL							
Paediatric Pfizer	Dose 1 5-11 years		Dose 2 5-11 years	0.0	Dose 3* 5-11 years					
Pfizer	Dose 1 12 years an	d above	Dose 2 12 years and	d above	Dose 3* 12 years and a	bove	Booster 1 16 years and abo	F	Booster 2 For those eligible 6 years and above	
AstraZeneca	Dose 1 18 years an	d above	Dose 2** 18 years and	d above	Dose 3* 18 years and a	above	Booster* 18 years and abo	ove		
Novavax	Dose 1 18 years ar	nd above	18 years an	d above	Booster 18 years and a		Booster 2 For those eligible 18 years and above			
* These doses are consid	7		nd primary do	ose following a) is considered of	f-label.
Vaccinator in	formation	1					i rea informa IEFI or obser		recorded	٦
Name	*		·			•	completed		recorded	J
Signature		70.				·		_		
Post vaccination	on informa	ition given			_		e			
Vaccination si When administed the consumer.			ofvaccine	, the clinica	al lead signs	as an inf	ormed conse	nt final cl	neck with	
Name										
Signature							Da	ate	/	YY
When a pres	cription is (used, the p	rescriber	must retai	n this form	or a cop	у,			

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Person	
Surname	First name
Phone	Date of birth / Age years
Address	DD MM YYYY
Medical Centre/GP	NHI
If you are receiving Pfizer, please let your vaccinator know:	Please let the vaccinator know:
If you are aged under 12 years you will get the	If you are unwellIf you are pregnant or breastfeeding
paediatric dose	If you're on blood-thinning medications or
 If you have had myocarditis or pericarditis after a vaccination in the past 	have a bleeding disorder
If you are receiving Novavax, please let your vaccinator know:	 If you've had a previous severe allergic reaction to any vaccine or injection in the past
If you are aged under 18 years	
I have read the COVID-19 information provi me information about the COVID-19 vaccin	
I have had a chance to ask questions and th	ney were answered to my satisfaction.
☐ I understand the benefits and risks of COVI	D-19 vaccination.
☐ I understand I will need 2 doses of the COVI	D-19 vaccine to be fully vaccinated.
I have been told how to seek assistance if le	experience symptoms that may be vaccine side effects.
I understand the side effects associated wi	th this vaccine and know how to get help if needed.
Signature	Date/
	DD MM YYYY
Parent / legal guardian / enduring power of a	uttorney
I am the parent, legal guardian or enduring power person named above.	er of attorney, and agree to the COVID-19 vaccination of the
Name of parent or legal guardian	Phone
Relationship to person being vaccinated	
Signature	Date / /
olg/latears -	Date/
ick the vaccine dose that applies:	
Paediatric Pfizer Dose 1 Dose 2 5-11 years Dose 2	Dose 3* 5-11 years
Pfizer Dose 1 12 years and above Dose 2 12 years and above	Dose 3* Booster 1 12 years and above 16 years and above 16 years and above 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
understand that I am receiving a vaccine as indica agree to receive the vaccine indicated above.	ated above and understand the information given to me.
ignature	
These doses are considered off-label use. ** A second primary	dose following another COVID-19 vaccine

Authorised pre I confirm that I h to the person na	nave explai	ned the re	easons fo	r, the risks	and benef		•	• •	•
Name							APC numb	oer	
Signature							Date	//_	
For prescription	n requirem	ents pleas	e see the i	elevant Po	licy Statem	nent.	DD	141141	1111
Information for \	/accinato	r							
Details confirmed	I 🗌		Positive	e answer to	o any scree	ening qu	estions? Ye	s No	
Record information	on and adv	ice given:					0		~60°
Informed consent	t obtained	? Yes 🗌	No 🗌	Date	e/_	M / YY	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		7				
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	d above	Dose 2 12 years and	d above	Dose 3* 12 years and a	above	Booster 1 16 years and abo	For	ooster 2 those eligible years and above
Novavax	Dose 1 18 years an	nd above	Dose 2** 18 years an	d above	Booster 18 years and a	above	Booster 2 For those eligible 18 years and abov	re	
*These doses are consid	ered off-label	use. ** A seco	nd primary d	ose following a	nother COVID-	-19 vaccine	(i.e., a mixed dose	e schedule) is	considered off-label
Vaccinator in	formation						rea informa		
Name				_		•	EFI or obser		ecoraea
Signature	•		<u> </u>			·		_	
Post vaccination	on informa	tion given			•		e		
Vaccination si When administe the consumer.			ofvaccine	e, the clinica	al lead signs	as an inf	ormed conser	nt final che	eck with
Name									
Signature							Da	ate	//
When a prese							у,		





Person					
Phone		Dat	e of birth/_	/Age	years
Address				MI 1111	
Medical Centre/0	GP			NHI	
in the past If you are unwell If you're on block have a bleeding If you've had a part to any vaccine of the company of the	myocarditis or period od-thinning medicat disorder previous severe aller or injection in the pas the COVID-19 infor ation about the COV a chance to ask que ad the benefits and ad I will need 2 dose a told how to seek as	ions or gic reaction st mation provided, a VID-19 vaccine. estions and they we risks of COVID-19 v s of the COVID-19 v ssistance if I experi	vaccinator know If you are aged upaediatric dose If you are receiving vaccinator know If you are aged upaccinator have had expression and the following accination. Vaccine to be fully vence symptoms the	nder 12 years you will and Novavax, please I inder 18 years plained to satisfaction.	get the et your de effects.
Signature	?	5 (Date/_	
I am the parent, person named a Name of parent	legal guardian or elabove. or legal guardian		torney, and agree t	Phone Date /	
oignatare				DD / N	MM / YYYY
Tick the vaccine o	lose that applies:			ı	
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	16 years and above	Booster 2 For those eligible 6 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	
	am receiving a vac ne vaccine indicate		oove and understa	nd the information g	iven to me.
Signature				Date	_ / /
* These doses are consi	dered off-label use. ** A	second primary dose fo	llowing another COVID-1	9 vaccine	MM YYYY

(i.e., a mixed dose schedule) is considered off-label. For any off-label use of a vaccine a prescription is required.

Authorised pre	escriber (i	ncl. medi	cal pract	itioner, n	urse prac	titioner	or pharma	cy presci	iber)
I confirm that I h to the person na						fits of the	e Pfizer or N	ovavax ∨	accination
Name							APC numb	oer	
Signature							Date	/ /	
For prescription	n requireme	ents please	e see the r	elevant Po	licy Staten	nent.	טט	IAIIAI	111
Information for \	/accinato	r							
Details confirmed	I 🗌		Positive	e answer to	any scree	ening qu	estions? Ye	s No	
Record information	on and adv	ice given:					0		20
Informed consent	t obtained'	? Yes 🗌	No 🗌	Date	e/_	M / YYY	Time		5)
Vaccine						1	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	d above	Dose 2 12 years and	d above	Dose 3* 12 years and a	above	Booster 1 16 years and abo	For	oster 2 those eligible rears and above
Novavax	Dose 1 18 years an	nd above	Dose 2** 18 years and	d above	Booster 18 years and	above	Booster 2 For those eligible 18 years and above	/e	
* These doses are consid	ered off-label	use. ** A secon	nd primary do	ose following a	nother COVID	-19 vaccine	(i.e., a mixed dose	e schedule) is	considered off-label.
Vaccinator in	formation				Observ	vation a	rea informa	ation	
Name						•	EFI or obser		corded
Signature	•		•			•	ompleted [_	
Post vaccination		tion given			_				
1 OSt Vaccination	ontinonna	idorrgiveri			Depart	ture time	9		
Vaccination s When administe the consumer.			ofvaccine	, the clinica	ıl lead signs	as an info	ormed conse	nt final che	ckwith
Name									
Signature							Da	ate/	/ /
When a pres							/,		



Surname	Person									
Address Medical Centre/GP	Surname			First name						
Address Medical Centre/GP	Phone		Dat	Date of birth / Age years						
If you are receiving Pfizer, please let your 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 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	Address			יוויו טט	1111					
If you have had myocarditis or pericarditis in the past If you are unwell If you are unwell If you are unwell If you are oblood-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 aged under 12 years you will get the paediatric dose If you are aged under 18 years If you are a	Medical Centre/G	SP			NHI					
If you are aged under 12 years you will get the paediatric dose If you're on blood-thinning medications or have a bleeding disorder If you're had a previous severe allergic reaction to any vaccine or injection in the past If you are receiving Novavax, please let your vaccinator know: If you are aged under 18 years If you are aged under 18 years you will get the paediatric dose If you are aged under 18 years you will get the paediatric you watching needications If you are aged under 18 years you will get the paediatric years you will get the paediatric years you will get the paediatric you have had a previous per level your vaccinator waccinator w						t your				
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 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 l 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 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 Dose 1 Signature Dose 1 Dose 2 Sill years and above Novavax Dose 1 Revers and above Novavax Dose 1 Revers and above Reposter Booster 1 Reposter 2 For those eligible to years and above Reposter 3 Reposter 2 For those eligible to years and above Reposter 3 Reposter 3 Reposter 4 Reposter 4 Reposter 4 Reposter 5 Reposter 6 Reposter 6 Reposter 7 Reposter 8 Reposter 1 Reposter 9 Reposter 1 Reposter 9 Reposter 1 Reposter 2 Reposter 3 Reposter 1 Reposter 3 Reposter 4 Reposter 4 Reposter 4 Reposter 4 Reposter 4 Reposter 5 Reposter 6 Reposter 7 Reposter 3 Reposter 1 Reposter 3 Reposter 4 Reposter 3 Reposter 4 Reposter 3 Reposter 4 Reposter 3 Reposter 4 Reposter 5 Reposter 4 R	•	nyocarditis or perica	rditis			ll get the				
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 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 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 D										
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 D / MM / YYYY		_	ns or	•		elet your				
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/M_/				If you are aged un	nder 18 years					
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				nd/o <mark>r</mark> have had exp	olained to					
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	☐ I have had a	chance to ask ques	tions and they we	re answered to my	satisfaction.					
I understand the side effects associated with this vaccine and know how to get help if needed. Signature	I understan	d the benefits and ri	sks of COVID-19 v	accination.						
Signature Parent / legal guardian / enduring power of attorney Date DD / MM / YYYY Lam 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 Fick the vaccine dose that applies: Paediatric Pfizer Dose 1 Dose 2 Dose 3' S-11 years Figure Dose 1 Dose 2 Dose 3' Dose										
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 Dose 1 Dose 2 Dose 3' S-11 years Pfizer Dose 1 Dose 2 Dose 3' S-11 years Pfizer Dose 1 Dose 2 Dose 3' Dos	I understan	d the side effects as	sociated with this	vaccine and know	how to get help if n	eeded.				
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 Date Dose Dose 1 S-11 years Dose 1 12 years and above Novavax Dose 1 18 years and above Dose 2 12 years and above Booster 1 16 years and above Booster 2 For those eligible 16 years and above Rosers and above Booster 2 For those eligible 16 years and above Rosers and above Novavax	Signature			70,						
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 Date Dose Signature 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 Novavax Dose 1 18 years and above Booster 2 For those eligible 16 years and above Rosers and above	Parent / legal g	uardian / end <mark>urin</mark> g	power of attorn	еу	Date/	/				
of the person named above. Name of parent or legal guardian Relationship to person being vaccinated		- (0)		*		1111				
Relationship to person being vaccinated		- /-	during power of at	torney, and agree t	o the COVID-19 va	ccination				
Relationship to person being vaccinated										
Signature Date					Dhara					
Paediatric Pfizer Dose 1 5-11 years Dose 2 5-11 years Dose 3 5-11 years Dose 3 5-11 years Dose 1 12 years and above Dose 2 12 years and above Dose 3 12 years and above Dose 3 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 Booster 2 For those eligible 18 years and above Royars and above Royars and above	Relationship to p	person being vaccina	ated		Pnone					
Paediatric Pfizer Dose 1 5-11 years Dose 2 5-11 years Dose 3 5-11 years Dose 3 12 years and above Booster 1 16 years and above Booster 2 For those eligible 16 years and above Novavax Booster 2 For those eligible 18 years and above 18 years and above Rose 1 18 years and above	Signature	- 1.0			Date $_{_{\overline{DD}}}/$	/				
Paediatric Pfizer Dose 1 5-11 years Dose 2 5-11 years Dose 3 5-11 years Dose 3 12 years and above Booster 1 16 years and above Booster 2 For those eligible 16 years and above Novavax Booster 2 For those eligible 18 years and above 18 years and above 18 years and above	Fick the vaccine o	ose that applies:								
Pfizer Dose 1 12 years and above Dose 2 12 years and above Dose 3* 12 years and above Dose 3* 12 years and above Dose 1 18 years and above Dose 2** 18 years and above Dose 2** 18 years and above Dose 3* 12 years and above Booster 1 16 years and above Booster 2 For those eligible 18 years and above Booster 2 For those eligible 18 years and above	X	Dose1								
Novavax 18 years and above	Pfizer	Dose 1	Dose 2	Dose 3*		For those eligible				
understand that Lam receiving a vaccine as indicated above and understand the information given to me	Novavax				For those eligible					
agree to receive the vaccine indicated above.				pove and understar	nd the information	given to me.				
Signature Date / /	Signature				Data	/ /				
Signature Date / / / YYYY * These doses are considered off-label use. ** A second primary dose following another COVID-19 vaccine	· ·	dered off-label use. ** A se	econd primary dose fo	lowing another COVID-19	9 vaccine	DD / MM / YYYY				

(i.e., a mixed dose schedule) is considered off-label. For any off-label use of a vaccine a prescription is required.

Authorised pre	•		•		· ·		•	•	-
to the person na									
Name							APC numb	oer	
Signature							Date	//	
For prescription	requirem	ents pleas	e see the r	elevant Po	olicy Statement		טט	IvIIvI	Y Y Y Y
Information for V	/accinato	r							
Details confirmed		Positiv	/e answer	to any sc	reening questi	ons?	Yes 🗌 I	No 🗌	
If yes, record infor	mation an	d advice g	given:				-0		30'
Informed consent	obtained	? Yes 🗌	No 🗌	Dat	e//_	YYYY	Time _		
Vaccine							Diluent	X	Pfizer only
Name of vaccine	Date	Time	Dose	Site	Batch Ex	piry	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 an	d above	Dose 2 12 years and	d above	Dose 3* 12 years and above		Booster 1 16 years and abo	For	those eligible vears and above
Novavax	Dose 1 18 years ar	nd above	Dose 2** 18 years an	d above	Booster 18 years and above		Booster 2 For those eligible 18 years and abov		
*These doses are conside	ered off-label	use. ** A secon	nd primary do	ose following	another COVID-19 va	ccine (i.	.e., a mixed dose	e schedule) is	considered off-label.
Vaccinator inf	ormation				Observation				_
Name					Details of a	·		vations re ¬	ecorded
Signature	•		•		•			_	
Post vaccinatio	on informa	ition given			Signature ₋ Departure				
Vaccination si When administe the consumer.			ofvaccine	, the clinic	al lead signs as al	n infoi	rmed consei	nt final che	eck with
Name							_		
Signature							Da	ate	/ /
					in this form or a with local policy.				



Person									
Surname			First name						
Phone		Da	te of birth /	/	Age y	ears			
Address			DD M	M YYYY					
Medical Centre/G	GP			NHI		-0			
 Please let the va If you have had after a vaccinat If you are pregn If you have diab If you are unwel 	myocarditis or per ion in the past ant or breastfeedin etes Il	icarditis ng	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						
	orevious severe alle or injection in the p	•	V/A		,				
me informat I have had a compared in the second in the se	he COVID-19 informion about the COV chance to ask quest the benefits and resold how to seek as	ID-19 vaccine. stions and they we isks of COVID-19 va sistance if I experie	re answered to my saccination. ence symptoms that	satisfaction. at may be vac how to get he					
I am the parent, lo of the person nar	ardian / enduring egal guardian or en ned above. or legal guardian		•	o the COVID-	19 vaccination				
Relationship to p	erson being vaccin	ated		Phone	e				
Signature				Date	///	<u></u>			
Tick the vaccine o	lose 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 abo	ove Booster For those e 16 years an	eligible			
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 abov					
l agree to receive th	am receiving a vac ne vaccine indicate	d above.		and the inform					
	dered off-label use. ** A edule) is considered off-			13 Vaccine		YYYY			

Authorised pre I confirm that I h to the person na	ave explai	ned the re	easons fo	r, the risks	and benefits o		•	•	•	
Name						_	APC num	ber		
Signature	Signature					_	Date	//		
For prescription	n requirem	ents pleas	e see the r	elevant Po	olicy Statement.		DD	MM	YYYY	
Information for V	/accinato	r								
Details confirmed		Positiv	/e answei	r to any so	reening questic	ons?	Yes 🗌	No 🗌	o V	
If yes, record infor	mation an	d advice g	given:						0,0	
Informed consent	obtained	? Yes 🗌	No 🗌	Dat	e//_	YYYY	Time _		7	
Vaccine							Diluen	t	Pfizer only	
Name of vaccine	Date	Time	Dose	Site	Batch	piry	Batch	Expiry	Time of reconstitution	
Paediatric Pfizer			0.2mL							
Pfizer/BioNTech			0.3mL			C	*			
Novavax			0.5mL		1 . (
Paediatric Pfizer	Dose 1 5-11 years		Dose 2 5-11 years		Dose 3* 5-11 years					
Pfizer	Dose 1 12 years an	d above	Dose 2 12 years and	d above	Dose 3* 12 years and above		Booster 1 16 years and ab	F	Booster 2 For those eligible 6 years and above	
Novavax	Dose 1 12 years an	nd above	Dose 2** 12 years an	d above	Booster 18 years and above		Booster 2 For those eligible 18 years and abo	e D		
* These doses are conside	ered off-label	use. ** A secor	nd primary do	ose following	another COVID-19 vac	ccine (i	.e., a mixed dos	se schedule)) is considered off-label.	
Vaccinator inf	ormation				Observation				_	
Name					Details of any AEFI or observations recorded CARM Papart completed					
Signature	•		>		CARM Report completed					
Post vaccination information given					Signature Departure time					
Vaccination si When administe the consumer.			ofvaccine	e, the clinic	al lead signs as ar	n info	rmed conse	ent final cl	neck with	
Name										
Signature							D	ate	_ / /	
					in this form or a dwith local policy.					



Ferson										
Phone		Da ⁻	te of birth/_	_/	Agey	/ears				
Address			Date of birth / MM / Age years							
Medical Centre/G	GP		NHI							
 after a vaccinate If you are pregned If you have diabed If you are unweld If you're on block or have a bleed If you've had a pregned 	myocarditis or per cion in the past pant or breastfeedin petes Il pd-thinning medica	ng ations rgic reaction	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							
me informat I have had a compared in the second in the se	he COVID-19 informion about the COV chance to ask quest the benefits and r cold how to seek as the side effects as	ID-19 vaccine. stions and they were isks of COVID-19 vacsistance if I experiessociated with this	e answered to my saccination. ence symptoms that	satisfaction. at may be vac now to get he						
I am the parent, le of the person nar Name of parent o	egal guardian or en med above. or legal guardian erson being vaccin	during power of att	•	Phone						
Tick the vaccine o	lose 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 abo	Booster For those of 16 years an	eligible				
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 abov	/e					
I agree to receive the Signature	am receiving a vac ne vaccine indicate dered off-label use. ** A	cine as indicated and above.	bove and understa	and the inform Da	nation given to	,				
(i.e., a mixed dose sche	edule) is considered off-	label. For any off-label	use ot a vaccine a presc	ription is require	ed.					

Authorised pre	escriber (i	ncl. medi	cal pract	titioner, r	nurse prac	titioner	or pharma	cist pres	criber)		
I confirm that I h to the person na	•					fits of the	e Pfizer or N	l ovavax ∨	accination		
Name							APC numl	oer			
Signature	Signature					Date	//				
For prescription	n requirem	ents pleas	e see the r	elevant Po	olicy Staten	nent.	טט	IMIM	Y Y Y Y		
Information for \	/accinato	r									
Details confirmed		Positiv	ve answei	rto any sc	reening qu	estions?	Yes 🗌	No 🗌			
If yes, record infor	mation an	ıd advice g	given:				0		20°		
Informed consent	t obtained	? Yes 🗌	No 🗌	Dat	re/_	M / YYYY	Time _				
Vaccine							Diluent		Pfizer only		
Name of vaccine	Date	Time	Dose	Site	Batch	Expiry	Batch	Expiry	Time of reconstitution		
Paediatric Pfizer			0.2mL		70			,			
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 an	d above	Dose 2 12 years and	d above	Dose 3* 12 years and a	above	Booster 1 16 years and ab	For	those eligible vears and above		
Novavax	Dose 1 12 years ar	nd above	Dose 2** 12 years an	d above	Booster 18 years and	above	Booster 2 For those eligible 18 years and above				
* These doses are conside	ered off-label	use. ** A secon	nd primary do	ose following	another COVID	-19 vaccine	(i.e., a mixed dos	e schedule) is	considered off-label.		
Vaccinator in	formation						rea informa				
Name					Details of any AEFI or observations recorded CARM Report completed						
Signature	•		>								
Post vaccination information given					Signature Departure time						
Vaccination si When administe the consumer.			ofvaccine	, the clinic	al lead signs	as an info	ormed conse	nt final che	eck with		
Name											
Signature							Da	ate	///		
When a prese							/,				





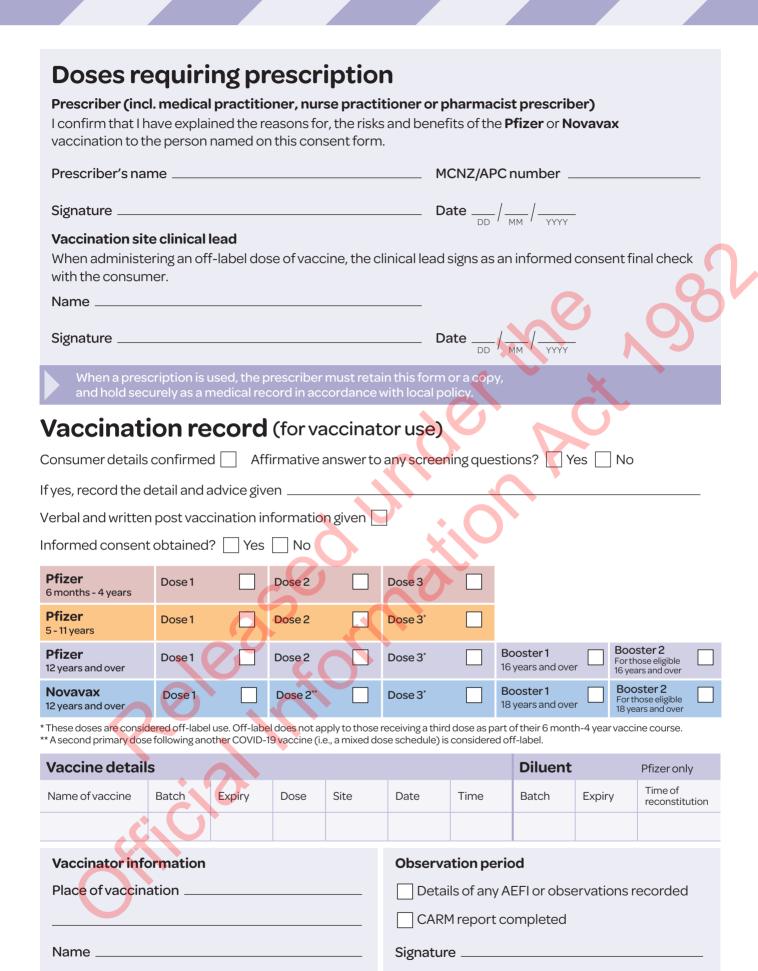


Person	
Surname	First name
Phone	Date of birth/ Age years
Address	DD MIN TITT
Medical Centre/GP	
Ethnicity (please tick one or more)	National Health Index number if known
NZ European Māori Samoan Cool	k Island Māori 🔲 Tongan 📗 Niuean 🔲 Chinese
Indian Other - please state	
Consent statements	70 00
I have 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	rthe vaccination.
The benefits and risks of the COVID-19 vaccine	have been explained to me.
The common and rare side effects of the COVID	0-19 vaccine have been explained to me.
I had enough time to ask questions and my ques	stions were answered to my satisfaction.
I have received or photographed the fact sheets	s 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'	
that may be vaccine related.	the person being vaccinated experience symptoms
I understand this vaccination information will be person's regular healthcare provider.	e recorded and shared with my/the vaccinated
I consent to the COVID-19 vaccination being g	iven.
Signature	Date///
As parent / legal guardian / enduring power of atte	orney
attorney, and agree to the COVID-19 vaccination of the	am the parent, legal guardian or enduring power of ne person named above.
Relationship to person being vaccinated	Phone
Signature	Date///
	Mā tātau
Te Kāwanatanga o Aotearoa	katoa e Te Whatu Ora
New Zealand Government	Health New Zealand

1 | English | COVID-19 vaccine consent form

HP7565 | 02.02.23

COVID-19



(

Te Kāwanatanga o Aotearoa

New Zealand Government



Departure time _





Signature _

Person	
Surname	First name
Phone	Date of birth $\frac{1}{100} / \frac{1}{100} / \frac{1}{100} $ Age $\frac{1}{100}$ years
Address	
Medical Centre/GP	
Ethnicity (please tick one or more)	National Health Index number if known
NZ European Māori Samoan Cool	k Island Māori 🔲 Tongan 🔲 Niuean 🔲 Chinese
☐ Indian ☐ Other – please state	<u> </u>
Consent statements	76, 60,
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	0-19 vaccine have been explained to me.
I had enough time to ask questions and my ques	stions were answered to my satisfaction.
	s so I can refer to them after I leave the appointment.
'What you need to know about the COVID-19' (After the COVID-10 years in this now).	vaccination'
• 'After the COVID-19 vaccination'	
that may be vaccine related.	he person being vaccinated experience symptoms
I understand this vaccination information will be person's regular healthcare provider.	e recorded and shared with my/the vaccinated
☐ I consent to the COVID-19 vaccination being g	iven.
Signature	Date//
As parent / legal guardian / enduring power of atte	orney
Iattorney, and agree to the COVID-19 vaccination of the	am the parent, legal guardian or enduring power of ne person named above.
Relationship to person being vaccinated	Phone
Signature	Date//

Te Kāwanatanga o Aotearoa

New Zealand Government





Doses red	quiring pre	scription								
	l. medical practition ave explained the r	•	•		•	_				
	ne person named o			111.3 01 1	ne Filzer of N	Ovavax				
Prescriber's na	me		М	ICNZ/A	PC number _					
Signature			D	ate	////	_				
Vaccination sit	e clinical lead			DE	O'MM' YYYY					
When administe with the consum	ering an off-label do ner.	se of vaccine, the	e clinical lead	signs a	s an informed	consent fi	nal check			
Name										
Cierantum							95V			
) / MM / YYYY					
	cription is used, the purely as a medical re				ov.					
Vaccinatio	on record (f	or vaccinato	ruse)	1		X				
Consumer details	confirmed Af	firmative answer	to any sc <mark>re</mark> er	ning qu	estions? \(\square\) Y	es No				
If yes, record the c	detail and advice giv	ren								
Verbal and writter	n post vaccination ir	nformation given								
Informed consent	obtained? Yes	No								
COVID-19 vaccii	nation primary co	urse	X		COVID-19 va	accination	n 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. 16+ years for those of	Nuva	Yavax Daxovid Dears for those eligible			
Dose1	Dose1	Dose1	Dose 1		Dose1	Dose	e1			
Dose 2	Dose 2	Dose 2	Dose 2**		Dose 2	Dose	e 2 📗			
Dose 3	Dose 3*	Dose 3*	Dose 3*							
* These doses are consid ** A second primary dose	dered off-label use. Off-laber following another COVID-	el does not apply to tho -19 vaccine (i.e., a mixed	se receiving a thire I dose schedule) is	d dose as s conside	part of their 6 mont red off-label.	th-4 year vacc	ine course.			
Vaccine details	\cdot				Diluent (Comirnaty 3m	cg and 10mcg only)			
Name of vaccine	Batch Expiry	Dose Site	Date	Time	Batch	Expiry	Time of reconstitution			
Vaccinator info	ormation		Observa	ation p	eriod					
Place of vaccina	ation	Deta	ils of ar	ny AEFI or obse	ervations r	ecorded				
		CAR	CARM report completed							
Name			Signatur	Signature						
Signature			Departu	ıre tim	e					
To Vāvenote	unda o Aotoaroa			M	lā tātau					

Te Kāwanatanga o Aotearoa

New Zealand Government

Mā tātau katoa e ārai atu te COVID-19

Te Whatu Ora Health New Zealand

Person	
Surname	First name
Phone	Date of birth/ Age years
Address	
Medical Centre/GP	NHI
Ethnicity (please tick one or more)	National reality index number in 1981
NZ European Māori Samoan Cook	Island Māori 🔲 Tongan 📄 Niuean 📄 Chinese
☐ Indian ☐ Other – please state	
 'What you need to know about the COVID-19 v 'After the COVID-19 vaccination' 	the vaccination. have been explained to me. 1-19 vaccine have been explained to me. tions were answered to my satisfaction. aso I can refer to them after I leave the appointment. accination' he person being vaccinated experience symptoms recorded and shared with my/the vaccinated
Signature	Date///
As parent / legal guardian / enduring power of atto	orney
Iattorney, and agree to the COVID-19 vaccination of the	am the parent, legal guardian or enduring power of e person named above.
Relationship to person being vaccinated	Phone
Signature	Date//

Te Kāwanatanga o Aotearoa

New Zealand Government





Doses red	quiring pre	scriptic	n								
•	l. medical practiti		•	•		•	-				
	nave explained the r ne person named o				tits of t	he Pfizer or N	Novav	ax			
Prescriber's na	me			MCNZ/APC number							
Signature				D	ate	///					
Vaccination sit	e clinical lead				DL) ' MM ' YYYY					
When administe with the consum	ering an off-label do ner.	se of vaccine	e, the d	clinical lead	signs a	s an informed	dcons	ent fii	nal check		
Name											
Signature		D	ate	//			0				
When a prese	cription is used, the p cordance with local p	orescriber mu oolicy.	ust reta	ain this form	or a co	py, and hold s	curely	/ as a ı	medical		
Vaccinatio	on record (f	or vaccin	ator	use)	·						
Consumer details	confirmed Af	firmative ans	swert	any scree	ning qu	estions? 🔲	Yes [No			
If yes, record the c	detail and advice giv	en									
•	n post vaccination in		_	_ ()	ormed	conse <mark>nt</mark> obta	ined?	ΠY	es No		
Confirmed consu	mer has not tested	positive for C	COVID	- -19 in the la	st 6 ma	onths					
	sure recommende		`								
COVID-19 vaccina	ation primary cours	e				COVID-19 va	ccinati	ion ad	ditional dose		
Pfizer	Pfizer	Pfizer		Novavax		Pfizer		Nov	avax		
Comirnaty (3mcg) 6 months - 4 years	Comirnaty (10mcg) 5 – 11 years	Comirnaty (30)	0,	Nuvaxovid 12 years and	over	Comirnaty (15/15mc) Original/Omicron BA 16+ years for those	A.4/5		xovid ars for those eligible		
Dose1	Dose1	Dose 1		Dose 1		Dose		Dose	e [
Dose 2	Dose 2	Dose 2		Dose 2 [†]							
Dose 3	Dose 3*	Dose 3*		Dose 3*							
† A second primary dose	dered off-label use. Off-laber of following another COVID- meet severely immunocor	19 vaccine (i.e., a i	mixed do	ose schedule) is	consider	ed off-label.	-				
Vaccine details	. 0					Diluent	(Comirna	aty 3mc	g and 10mcg only)		
Name of vaccine	Batch Expiry	Dose Si	ite	Date	Time	Batch	Ехрі	ry	Time of reconstitution		
Vaccinator info	ormation			Observ	ation p	eriod					
Place of vaccina	ation			Deta	ils of a	ny AEFI or obs	servati	ions r	ecorded		
				CAR	М геро	rt completed					
Name				Signature							
Signature				Departu	ıre tim	e					
To Vāwanata	unda o Aotoaroa				M	lā tātau					

Te Kāwanatanga o Aotearoa

New Zealand Government

Mā tātau katoa e ārai atu te COVID-19

Te Whatu Ora Health New Zealand