HSE COVID 19 Vaccination Consent Form

FOR USE ONLY JANUARY 2021

Name: .... **PPSN (mandatory)**:.......................................

Part 1: Please answer all of the following questions:

Question	Answer Y/N as appropriate	Action based on response given to Question
Have you had Anaphylaxis (serious systemic allergic reaction requiring medical intervention) following a previous dose of the vaccine or any of its constituents, including polyethylene glycol?		If **yes**, you are **not** eligible for vaccination at this time
Have you been diagnosed with COVID-19 within the last 4 weeks?		If **yes**, you will **not** be eligible for vaccination until 4 weeks after your COVID symptoms finished
Have you had another vaccine within the last 14 days?		If **yes**, you will **not** be eligible until vaccine 14 days after your last vaccination
Do you have a bleeding disorder or are on anticoagulation therapy?		No action on either yes or no, knowledge transfer to vaccinator
Are you less than 14 weeks pregnant?		If **yes,** you are **not** eligible for vaccination at this time. If no and if you are more than 14 weeks pregnant and consenting to vaccination, please bring a letter from your obstetric care giver confirming you may receive the vaccine

Part 2: Please read the accompanying vaccine information leaflet and tick appropriate box below:

Yes	

- I have read and understand the vaccine information provided, including known side effects.
- I understand the COVID-19 vaccine is not recommended during pregnancy.
- I understand that I am giving consent for the administration of two doses of COVID-19 vaccine at the appropriate interval

No	

- No, I do not consent to be vaccinated to protect against COVID-19. I have read and understood the accompanying vaccine information provided including the risks of not vaccinating.

Signed:.. **Date:**..

Office Use Only:

Administered by: Signature .... Date:..

Block capitals .... An Bord Altranais PIN..................................

Intramuscular vaccination site. (Right) or (Left) Deltoid. Batch No sticker

Checked by: .... www.hse.ie/screening-and-vaccinations/covid-19-vaccine www.hse.ie/Coronavirus www.hpsc.ie

Kinsale Medical

Clients Information	Mandatory/ Optional	
Forename	M	
Surname	M	
Mothers Birth Family Name	Optional	
Middle Name	Optional	
Otherwise known as (Alias)	Optional	
Gender	M	
Date of Birth	M	
PPSN	M	
Contact Number (Mobile)	M	
Contact Number (Alternate)	M	
Preferred Method of Contact	Optional	
Email (Personal)	Optional	
Email (Alternate)	Optional	
Facility ID	M	
Address type	M	
Home Address Line 1 (Full Street Address)	M	
Home Address Line 2 (City)	M	
County	M	
Country	Optional	
Eircode	Optional	
Ethnicity	Optional	
Spoken language & other	Optional	
Priority	M	
Occupation	M	