**Year Group**

**Name of school:**



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| **SURNAME** |  | **FORENAME** |  |
| **DATE OF BIRTH** |  | **Is the child 12 year or over?** | **Yes / No** **(Under 12 do not vaccinate)** | **NHS NUMBER** |  |
| **SIGNATURE (Person with parental responsibility)** |  | **PARENTAL CONSENT YES/NO****(If no do not vaccinate)**  | **DATE** |  |
| **PRINT NAME (Parent/Legal Guardian/Parental Responsibility ):** |  | **RELATIONSHIP TO Child**  |  |
| **EMERGENCY CONTACT NUMBER**  | **Mobile:**  | **Landline** |
| **1st LINE OF ADDRESS** |  | **POSTCODE** |  |
| **ETHNICITY****(Please tick one)** | White |  | Asian/Asian British |  | Arab  |  | Black/African/Caribbean/Black British  |  |
| Mixed  |  | Mixed/multiple ethnic groups  |  | Other ethnic group  |  | Prefer not to say  |  |
| **Please indicate if this is:** |

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| --- | --- | --- |
| The First Covid Vaccine? Yes No

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| Date administered: |

The Second Covid Vaccine? Yes No

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| Date administered: |

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 | **Known Allergies (please list or write ‘none’):** |
| **Please read the COVID information leaflet you have been given before proceeding to the Pre-vaccination screening** |

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| **Pre-vaccination Screening** | **Circle** | **If you answer YES to any questions, please give details**  |
| 1. | Is your child currently unwell with a fever?  | Y | N |
| 2. | Has your child tested positive for COVID-19 within the last **12 weeks?** (If Clinical Vulnerable within 28 days)? if so date of positive test…………………………… | Y | N |
| 4. | Could your child be pregnant? If Yes, give pregnancy leaflet |  Y | N |
| 5. | **Has your child had a previous systemic allergic reaction (including immediate onset anaphylaxis) to a previous dose of COVID-19 mRNA Vaccine BNT162b2, other vaccine, medication or food especially if they have required hospital admission. Does your child have a EpiPen ?** | Y | N |
| 6. | Does your child have history of blood clots or a bleeding disorder e.g., haemophilia? | Y | N |
| 7. | Does your child have a history of heparin-induced thrombocytopenia and thrombosis (HITT or HIT type 2)? | Y | N |
| 8. | Has your child experienced major venous and/or arterial thrombosis occurring with thrombocytopenia following vaccination with any COVID-19 vaccine? | Y | N |
| 9. | Does your child take any regular medication or blood thinning medication e.g., warfarin Are you taking any blood thinning medication e.g., Warfarin?  | Y  | N |
| 10. | Has your child got any long-term medical condition that requires ongoing hospital treatment or is on a waiting list? please give details  | Y | N |

 **Please tick the relevant boxes and sign and date below:**

**BOX A:** I have read the information sheet and **consent** to receiving the COVID 19 vaccination. I am aware that the National Immunisation Vaccination (NIV) service / PharmOutcomes system and other Healthcare providers will be informed I have been vaccinated.

**OR**

**BOX B:** I have read the information sheet and following the pre-vaccination screening I am **NOT eligible** for vaccination.

**BOX C:** Advice for the public: Vaccinated individuals should be advised to seek immediate medical attention should they experience **new onset of chest**

**pain, shortness of breath, or symptoms of disturbance of cardiac rhythm**. The COVID-19 vaccines remain highly effective in protecting people from COVID-19 and have already

saved thousands of lives. These events are extremely rare and tend to be mild when they do occur. Our advice remains that the benefits of getting vaccinated outweigh the risks

in the majority of people. It is still vitally important that people come forward for their first and second vaccination when invited to do so, unless advised otherwise.

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| **REGISTRANT TAKING CONSENT**  | **PRINT NAME:** | **Signature:** | **Confirm child is over the age of 12 years – check DOB****Please circle Y N If no do not vaccinate** |
| **CLINICAL SUPERVISOR** |  |

**Date /Triaged by:**

**Please circle Y To Vaccinate**

 **N NO DO NOT VACCINATE**

**Please circle Y N If no do not vaccinate**

**Vaccination details – administered via National protocol or PGD for:**

**COVID-19 mRNA vaccine BNT162b2 (Pfizer/BioNTech) (COMINARTY)**

**Pl Please attach vaccine label – to include vaccine name, amount in mls to be given, batch number and expiry date:**

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| **VACCINE ADMINISTERED: YES / NO – vaccinator must confirm that child is 12 years and over – check DOB** |
|  | **Does the child consent to the vaccine? (circle)****Advice Given re: Safety Netting**  | **YES NO****YES NO** |
| **Vaccinator Profession:** |  |
| **Vaccinator ID:** |  |
| **Vaccinator Name / Stamp:** | ***PLEASE ENTER NAME IN CAPITALS***  |
|  |
| **Vaccination Site:** | Left upper arm |  |
| Right upper arm |  |
| **Which Dose:** | First dose of vaccine |  |
| Second dose of vaccine |  |
| **Vaccinator Signature:** |
| **Date:**  |
| **Time (24 hour):** |
| **VACCINE ADMINISTERED: NO** |
| **NOT VACCINATED? COMMENTS. PLEASE INCLUDE ADVICE GIVEN/PATIENT COMMENTS/REBOOKED DATE? ETC.** |

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| **(Q4 Q5) PREVIOUS ADVERSE REACTIONS** **TO VACCINE/DRUG** (*Please circle)* |
| **Reaction Type** | Allergy | Intolerance |
| **Reaction***(Please refer to sheet at data entry desk)* |  |
| **Criticality** | High | Low | Unable to assess |
| **Date First Experienced** |  |
| **Verification Status** | Confirmed | Suspected |

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| **OBSERVATIONS POST VACCINE** |
| *Recorded observations for any assistance required for the patient and actions taken* |
| **Date and Time:** | **Staff name/PIN number** |  |
| **Comments:** |
| **STAFF SIGNATURE:** |