

COVID-19 vaccination consent form

Patient

Surname First name

Phone Date of birth / / NHI

Address

Medical Centre/GP

Support person / guardian / enduring power of attorney

Name (if applicable)

Relationship to patient

Please let the vaccinator know:

- If you are unwell
- If you've had a previous severe allergic reaction to any vaccine or injection in the past
- If you're on blood-thinning medications or have a bleeding disorder
- If you've had any vaccines in the past four weeks
- If you are pregnant or breastfeeding
- If you are currently receiving the cancer drugs Keytruda, Opdivo, Yervoy, or Tecentriq or have done so in the past six months

I have read the COVID-19 information pamphlet on "What to Expect", 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.

Signature Date / /

I am the patient's support person, guardian, or enduring power of attorney, and agree to the COVID-19 vaccination of the patient named above

Signature Date / /

Unite
against
COVID-19

New Zealand Government



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

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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

