

COVID-19 Astra-Zeneca Vaccine Consent Form



Section 1: Personal Details *(to be completed by vaccinee)*

First name

Surname

Date of birth

— —

Age

Gender

Male

Female

Prefer not to say

Home address

Postcode

NHS number

— —

Tel number

Email address

GP name

GP practice

LHCH Trust employee

Other NHS employee

Social care employee

Care home employee

Local authority employee

LHCH staff relative

LHCH inpatient

LHCH outpatient

Primary care patient

Care home patient

Paid carer

Unpaid carer

Section 2: Consent *(to be completed by vaccinee)*

Please confirm the following statements by placing a tick in the box:

1. I confirm I have received and read the COVID-19 vaccine information leaflet. (tick)
2. I confirm I understand the risks and benefits of the COVID-19 vaccine being offered. (tick)
3. I understand that I must rebook and attend for the second dose of the vaccine as scheduled. (tick)
4. I consent to receiving the 1st and 2nd dose of the COVID-19 vaccine. (tick)

Signature

Date

— —

If you are completing this form on behalf of the individual in their best interest, please state:

Name

Relationship

Date of Birth

— —

Section 3: Pre-screening Assessment for Astra-Zeneca Vaccine Only *(to be completed by vaccinee)*

Please note: Exclusion does not necessarily mean the vaccine is contraindicated but would be outside protocol.

Email vaccine@lhch.nhs.uk to discuss alternative assessment.

Are you feeling unwell today?	No	Yes	exclude: do not give
Do you have any COVID-19 symptoms? <i>(i.e. high temperature, a new continuous cough, a loss or change with your sense of smell or taste)</i>	No	Yes	exclude: advise to self isolate
Previous systemic allergic reaction (including immediate onset anaphylaxis) to a previous dose of a COVID-19 mRNA vaccine or to any component of the vaccine or residues from the manufacturing process?	No	Yes	exclude: refer to allergist
Have a history of immediate anaphylaxis to multiple, different drug classes, with the trigger unidentified (this may indicate polyethylene glycol 'PEG' allergy)?	No	Yes	exclude: refer to allergist
Have a history of anaphylaxis to a vaccine, injected antibody preparation or a medicine likely to contain PEG (such as depot steroid injection, laxative)?	No	Yes	exclude: refer to allergist
Have a history of idiopathic anaphylaxis?	No	Yes	exclude: refer to allergist
Have you had a previous dose of the COVID-19 vaccine? If yes, what was the date? — —	No	Yes	do not give within 28-days of 1st dose or 12-weeks after 1st dose unless authorised by clinical supervisor
What was the brand Astra-Zeneca vaccine? If not Astra-Zeneca please specify	No	Yes	do not give if not Astra-Zeneca
Have you already completed a course of COVID-19 vaccination?	No	Yes	exclude: do not give
Have you participated in a COVID-19 vaccine clinical trial?	No	Yes	refer back to trial investigators written consent required
Have you had confirmed COVID-19 infection in last 4-weeks?	No	Yes	exclude: do not give
Have you received any other vaccine in the last 7-days?	No	Yes	exclude: do not give
Are you immunosuppressed or taking immunosuppressants?	No	Yes	counsel for reduced response
Are you about to commence immunosuppressant therapy?	No	Yes	vaccinator to discuss 2nd dose interval
Are you taking anticoagulants? (Ensure INR not above range)	No	Yes	apply pressure for 2-mins
Do you have a disorder that makes you prone to bleeding?	No	Yes	apply pressure for 2-mins
Are you under 18-years of age?	No	Yes	exclude: do not give
Are you or could you be pregnant? If YES, risk/benefit as per RCOG	No	Yes	See clinical supervisor
Are you breastfeeding?	No	Yes	read current Gov information
Do you have a BMI over 40?	No	Yes	use longer needle
Previous major thrombosis & low platelets with ANY COVID vaccine?	No	Yes	exclude: do not give
History of cerebral venous thrombosis/HIT/antiphospholipid syndrome?	No	Yes	review risk/benefit (can give Pfizer)

If you have answered yes to any of the above please provide further details:

Name:

Date of birth: — —

Section 4: Eligibility and Administration Record *(to be completed by vaccinator if no access to online NIMS database)*

I have confirmed the individual's personal details as per section 1? Yes

Does the individual meet any exclusion criteria? No Yes exclude: do not give

Has the individual had the opportunity to ask any questions? No Yes

Has the individual provided signed consent in section 2? No Yes

Are any additional precautions or advice required? (e.g. bleeding risk)? No Yes

If yes please provide details:

Vaccination site: Right deltoid Left deltoid Other (note this is off-label)

If other, state site and rationale:

Is this the 1st / 2nd dose?: 1st dose 2nd dose

Batch number:

Time of administration: —

Size of needle used?: Standard (23G x 25mm) Longer (23G x 38mm)

Please provide details of any advice given on discharge about adverse effects:

Advised on 15-min post vaccine wait time? Yes

Vaccinator first name:

Vaccinator surname:

Profession: Doctor Nurse / Midwife Nursing Associate Pharmacist

Operating department practitioner Physiotherapist Paramedic

Other, please state:

Section 5: Adverse Drug Reaction *(to be completed by vaccinator)*

Did a reaction occur? No Yes

If yes, please give details:

If yes, please complete yellow card report via MHRA (<http://coronavirus-yellowcard.mhra.gov.uk>)