**CONSENT FORM –**



The COVID-19 vaccine is being offered to your child. Your child will receive their first COVID-19 vaccine and you may be notified about the second dose later. Further information can be found on the DfE website:

<https://www.gov.uk/government/publications/covid-19-vaccination-resources-for-children-and-young-people>Please discuss the vaccination with your child, then complete this form by:

Information about the vaccinations will be put on your child’s health records.

|  |  |
| --- | --- |
| Child’s full name (first name and surname): | Date of birth: |
| Home address:  | Daytime contact telephone number for parent/carer: |
| NHS number (if known): | Ethnicity: |
| School (if relevant): | Year group/class: |
| GP name and address: |

**Ask ALL patients ALL questions below and tick if any apply**

**EXCLUSION CHECKLIST – tick any that apply**

* **Has your child tested positive for COVID-19 in the** **last 12 weeks (by a lateral flow test or a PCR test)? If so, please provide the date on which your child tested positive:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Has the individual experienced major venous and/or arterial thrombosis occurring with thrombocytopenia following vaccination with any COVID-19 vaccine?**
* **Has the individual had any vaccination in the last 7 days?**
* **Is the individual currently unwell with fever?**
* **Does the individual have an allergy to any medications?**
* **Has the individual ever had an anaphylactic reaction?**
* **Does the individual take any regular mediation if so what? Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Does the individual have a history of heparin-induced thrombocytopenia and thrombosis (HITT or HIT type 2)?**
* **Does the individual have a history of capillary leak syndrome?**
* **None of the above**

**CAUTION CHECKLIST – tick any that apply**

* **Has the individual indicated they are, or could be pregnant?**
* **Has the individual informed you they are currently or have been in a trial of a potential coronavirus vaccine?**
* **Is the individual taking anticoagulant medication, or do they have a bleeding disorder?**
* **Does the individual currently have any symptoms of Covid-19 infection?**
* **None of the above**

|  |  |  |
| --- | --- | --- |
| I **want** my child to receive the COVID-19 vaccination |  | I **do not want** my child to have the COVID-19 vaccine |
| Name:  | Name: |
| Signature:Parent/Guardian | Signature:Parent/Guardian |
| Date: | Date: |