

Adults

COVID-19 vaccination consent form

The COVID-19 vaccination will reduce the chance of you suffering from COVID-19 disease. Like all medicines, no vaccine is completely effective and it takes a few weeks for your body to build up protection from the vaccine. Some people may still get COVID-19 despite having a vaccination, but this should lessen the severity of any infection. If you are currently pregnant, planning pregnancy or breastfeeding please read the detailed information at www.nhs.uk/covidvaccination

The vaccine cannot give you COVID-19 infection, and two doses will reduce your chance of becoming seriously ill. You will still need to

follow the guidance in your workplace, including wearing the correct personal protection equipment and taking part in any screening programmes. Like all medicines, vaccines can cause side effects. Most of these are mild and short-term, and not everyone gets them.

Please read the product information for more details on the vaccine and possible side effects by searching Coronavirus Yellow Card. You can also report suspected side effects on the same website or by downloading the Yellow Card app. Visit coronavirus-yellowcard.mhra.gov.uk

Full name (first name and surname):

ERIC CARNEY

Date of birth:

2002/01/08

Home address:

9, DOWNLANDS ROAD, CROYDON, CR8 4JG

Daytime contact telephone number:

077911 234567

NHS number (if known):

0009480516

Ethnicity:

HISPANIC

Care home address:

~~DUDLEY WOODS~~

Gender (circle as appropriate):

☒ Male

Female

Prefer not to say

GP name and address:

DUDLEY WOODS SURGERY

☐ I am a woman of childbearing age and I have read the leaflet on pregnancy and breastfeeding

Consent for a course of COVID-19 vaccination (please complete one box only)

I want to receive the full course of COVID-19 vaccination

Name

Signature

Date

I do not want to receive the full course of COVID-19 vaccination

Name

ERIC CARNEY

Signature

[Signature]

Date

JUNE 23, 2021

If, after discussion, you decide that you do not want to have the vaccine, it would be helpful if you would give the reasons for this below/on the back of this form (and return to the provider).

Severe allergic reaction to a vaccine in the past.

Please take this consent form to your vaccination appointment. You may be asked to complete it there.

Office use only

Date of COVID-19 vaccination	Site of injection (please circle)		Batch number/ expiry date	Brand of Vaccine	Immuniser name and signature (please print)	Where administered (care home, home, GP etc)
First	L arm	R arm	<i>[Signature]</i>	<i>[Signature]</i>		
Second	L arm	R arm				