

Vaccination Consent Form for people receiving COVID-19 vaccine

For the latest Comirnaty® antigenically updated vaccine for people aged 6 months to 4 years

COMPLETE THE FORM IN BLOCK CAPITALS USING A PEN

Please complete the details in Parts 1-3 of this consent form and return it to your vaccinator.

PART 1: PERSONAL DETAILS																			
Complete this part with details for the person being vaccinated (PLEASE USE BLOCK CAPITALS)																			
First Name																			
Middle Name																			
Surname (Family Name)																			
Otherwise Known As																			
Personal Public Services Number (PPSN)																			
Date of Birth	D	D	M	M	Υ	Υ	Y	Υ			Se	x at E	Birth:	1	Male		Fer	male	
Address																			
County																			
Eircode																			
Mother's Surname at Birth (Maide			ame)																
Email																			
Mobile Phone Number																			
Daytime Phone Number																			
Country of Birth																			
Ethnic or cultural background A. White		Blad	ck or	Blac	k Irisł	1	C	c. Asi	ian oı	r Asia	n Iris	h	ſ		her, i		ling m	nixed	
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A.3 Roma A.4 Any other White			50	.ogr	Jana		(C.3	つ A	ny otl ackgr	her A	sian	D.2 Mixed, write in description D.3 Other, write in description						
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D. Description																			
E Prefer not to say																			



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The Immunisation Team may need to contact you to discuss details provided in this form. Please note, we may send you an appointment confirmation and/or reminders by SMS and/or email.

PA	RT :	2: MEDICAL DETAILS		
Pleas	se ai	nswer the following questions about the person to be vaccinated with a yes or no answer		
1.		s this person ever had a serious allergic reaction (anaphylaxis) that needed medical treatment?	Yes	No
	i.	after having a previous dose of the Moderna (Spikevax®) or any Pfizer/BioNTech (Comirnaty®) COVID-19 Vaccines, OR		
	ii.	to any of the vaccine ingredients, including polyethylene glycol known as PEG, OR		
	iii.	to Trometamol (an ingredient in a contrast dye used in MRI radiological studies)?		
	If y	es, they cannot have this vaccine. If no, GO TO NEXT QUESTION.		
2.	Ha	ve they ever had a serious allergic reaction (anaphylaxis):	Yes	No
	i.	after taking multiple different medications, with no reason known for the reaction. This may mean they are allergic to polyethylene glycol (PEG), OR		
	ii.	after having a vaccine or medicine that contains polyethylene glycol (PEG), OR		
	iii.	for unexplained reasons? This may mean they are allergic to polyethylene glycol (PEG).		
	If y	es, they cannot get this vaccine today, they should get specialist advice. Talk to the vaccination team.		
	If n	o, GO TO NEXT QUESTION.		
3.		ve they ever had Mastocytosis (rare condition caused by an excess number of mast cells thering in the body's tissues)?	Yes	No
	,	es, they can still get the vaccine, BUT, they should be observed for 30 minutes after they are scinated.		
	If n	o or yes, GO TO NEXT QUESTION.		
4.		ve they had Myocarditis (inflammation of the heart muscle) or Pericarditis (inflammation of the ng around the heart) after having a previous dose of COVID-19 vaccine?	Yes	No
	If y	es, please answer question 4a.		
	If n	o, GO TO QUESTION 5.		
4a.	spe	ce they had myocarditis or pericarditis after a previous dose of the COVID-19 vaccine a ecialist doctor (Cardiologist) must approve that they can get this vaccine. Has their COVID-19 ecination been approved by a specialist doctor (Cardiologist)?	Yes	No
	If y	es, GO TO NEXT QUESTION.		
		o, they cannot get this vaccine today. They should talk to their specialist doctor (Cardiologist) to eck if they are suitable for this vaccine.		
5.		ve they had multisystem inflammatory syndrome also called MIS-C (a rare syndrome usually ated in hospital) after a COVID-19 infection?	Yes	No
	If y	es, please answer question 5a and 5b.		
	If n	o, GO TO QUESTION 6.		
5a.	Ha	ve they clinically recovered from MIS-C?	Yes	No
	If y	es, go to question 5b. If no, they will have to wait until they have clinically recovered from MIS-C.		
5b.	Has	s it been over 3 months since MIS-C was diagnosed?	Yes	No
		es, GO TO NEXT QUESTION. If no, they will have to wait at least 3 months after the diagnosis of S-C before they can get vaccinated.		
6.	Ha	ve they had the mpox vaccine (Imvanex or JYNNEOS) in the last 4 weeks?	Yes	No
	If y	es, they need to wait 4 weeks before getting a COVID-19 vaccine. If no, GO TO NEXT QUESTION		



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7.	Have they had a previous COVID-19 infection?	Yes	No
	If yes, and they are receiving a first dose of a COVID-19 vaccine, they should delay getting a vaccine until they have recovered from COVID-19 and it has been at least four weeks since they tested positive or developed symptoms.		
	If yes, and they have received a COVID-19 vaccine before, the vaccinator will advise if they need a vaccine and on when the vaccine should be given, based on current NIAC advice.		
	If no, and they are receiving a first dose of a COVID-19 vaccine, they should get a second dose of a COVID-19 vaccine 4 weeks after their first dose.		
	GO TO NEXT QUESTION.		
8.	Do they have a bleeding disorder or are they on anticoagulation therapy?	Yes	No
	If no, GO TO NEXT QUESTION.		
	If yes, GO TO NEXT QUESTION if the vaccinator approves vaccination with their bleeding disorder.		
9.	Have they had any other vaccines in the last 14 days, or are any other vaccines planned in the next 14 days?	Yes	No
	If yes, they cannot get this vaccine today.		
	If no, GO TO NEXT SECTION.		
	nplete this section if the child is getting a second or third dose of a COVID-19 vaccine after their first ause they have a weak immune system (immunocompromise)	dose	
10.	Are they receiving a second dose of a COVID-19 vaccine 4 weeks after their first dose because they have a weak immune system?	Yes	No
	If yes, GO TO QUESTION 10a.		\cup
	If no, GO TO QUESTION 11.		
10a.	Has it been at least 4 weeks since their 1st dose of the vaccine?	Yes	No
	If yes, GO TO QUESTION 10b.		
	If no, they should wait at least 4 weeks since their last dose.		
10b.	Have they been diagnosed with COVID-19 infection since their first dose of COVID-19 vaccine?	Yes	No
	If yes, they should wait at least 4 weeks from when they tested positive or developed symptoms before getting their second vaccine.		
	If no, GO TO NEXT QUESTION.		
11	Are they receiving a third dose of a COVID-19 vaccine after their second dose on the advice of a specialist doctor?	Yes	No
	If yes, GO TO QUESTION 11a		
	If no, GO TO NEXT SECTION.		
11a	If yes, has it been at least 4 weeks since their last COVID-19 vaccine dose?	Yes	No
	If yes, GO TO QUESTION 11b		
	If no, they should wait at least 4 weeks since the last COVID-19 vaccine.		
11b	If they are receiving a third dose of a COVID-19 vaccine after their second dose because they have a weak immune system, have they had COVID-19 infection since their second COVID-19 vaccine dose?	Yes	No
	If yes, the vaccinator will advise if they need a vaccine based on current NIAC advice.		
	If no, GO TO NEXT SECTION.		
Vac	cination may proceed if no issues for further investigation, deferral or contraindications are noted in the above	quest	ions.



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PART 3: VACCINATION CONSENT

Medical Consent: Please note only a parent or legal guardian can provide consent for a medical procedure, or refuse

COVID-19 Vaccine Prescriber's signatur MCRN/PIN	re and		tor's signa MCRN/PII		ınd	Ва	atch	No.		E	kpiry	Dat	е	D	ate	Give	n
sharing between HSE de				•													
processing of your / you manage the vaccinations																	ata
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transparency, to explain Notice for Patients and S	how we co	llect and u	se persona	al infor	matior	n the I	HŠE	prov	ides	s de	tails	withi	n the	HSE	Priv		
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This child assents to rece Thank you for completir	J	,	,	eturn it	to vo	ur va	ccin	ator.									
Please tick Parent	Le	gal Guardia	ın 🗌														
-														J			
Signature								D	ate	D	D	M	M	Y	Y	Y	Υ
Name (Please print)																	
I have read and under	rstand the	accompany	ing vaccir	ne infoi	rmatio	n, inc	ludir	ng kr	owi	n sic	le ef	ects					
 I understand I am givi 	ing consen	t for the ad	ministratio	on of a	dose	of CO	VID-	19 v	acc	ine a	at the	e app	ropri	ate i	nterv	al	
 I am authorised to give 	e consent	on behalf c	of the abov	ve nam	ed chi	ild											
by digiting the below 1 co	nfirm that:																
By signing the below I co	<i>c</i>																

				D	D	M	M	D	D	M	M			
				Υ	Υ	Υ	Υ	Υ	Y	Υ	Υ			
Vaccination Site	Right deltoid or Right vastus lateralis in the anterolateral thigh													
vaccination Site	Left deltoid or Left vastus lateralis in the anterolateral thigh													
Completed by:		MCRN/PIN:												
Date: D D M M Y	YYY													
If vaccine not administered pleas	For off	icial use only												
DNA or Absent		Notes/Comments:												
Refused on the Day														
Vaccine Contraindicated														
Deferred														
Other														