Vaccination Consent Form for people receiving COVID-19 vaccine

For the latest Nuvaxovid antigenically updated vaccine available for people aged 12 years and older

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 Service Number (PPSN)

Date of Birth D D M M Y Y Y Y

Sex at Birth: Male ☐ Female ☐

Address

County

Eircode

Mother's Surname at Birth (Maiden Name):

Is this person a:

Healthcare worker (HCW) ☐ Agency/Contractor HCW ☐ Long term Residential Care – Resident ☐ Other ☐

Other:

Email

Mobile Phone Number

Daytime Phone Number

Country of Birth

Ethnic or cultural background:

A. White

- ☐ A.1 Irish
- ☐ A.2 Irish Traveller
- ☐ A.3 Roma
- ☐ A.4 Any other White Background

B. Black or Black Irish

- ☐ B.1 African
- ☐ B.2 Any other Black background

C. Asian or Asian Irish

- ☐ C.1 Chinese
- ☐ C.2 Indian/Pakistani/ Bangladeshi
- ☐ C.3 Any other Asian background

D. Other, including mixed background

- ☐ D.1 Arab
- ☐ D.2 Mixed, write in description
- ☐ D.3 Other, write in description

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.

Part 2: MEDICAL DETAILS

Please answer the following questions about the person being offered a COVID-19 vaccine with a yes or no answer

1. Do they have a contraindication to mRNA vaccines or have they made an informed choice not to get an mRNA vaccine? Yes ☐ No ☐

If yes, GO TO NEXT QUESTION. If no, they cannot get this vaccine. An mRNA vaccine can be offered if there are no contraindications.

2. Have they ever had a serious allergic reaction (anaphylaxis): Yes ☐ No ☐

i. After a previous dose of Nuvaxovid vaccine OR

ii. to any of the vaccine ingredients, including polysorbate 80?

If yes, they cannot get this vaccine. If no, GO TO NEXT QUESTION.

3. Have 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 polysorbate 80)? OR

ii. from a vaccine, injection of antibody preparation or a medicine likely to contain polysorbate 80 OR

iii. for unexplained reasons? This may mean they are allergic to polysorbate 80.

If yes, they need specialist advice prior to vaccination. If no, GO TO NEXT QUESTION.

4. Have they had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart) after having a previous dose of COVID-19 vaccine? Yes ☐ No ☐

If yes, they need to answer further question 4a. If no, GO TO QUESTION 5

4a. Since they had myocarditis or pericarditis after a previous dose of COVID-19 vaccine a specialist doctor (Cardiologist) must approve them to get this vaccine. Has their COVID-19 vaccination been approved by a specialist doctor (Cardiologist)? Yes ☐ No ☐

If yes, GO TO NEXT QUESTION. If no, they cannot get this vaccine. They need to talk to their specialist doctor (Cardiologist) to check if they are suitable for this or another type of COVID-19 vaccine.

5. Have they had an Mpox vaccine (Imvanex or JYNNEOS) in the last 4 weeks? Yes ☐ No ☐

If yes, they cannot get this vaccine today. If no, GO TO NEXT QUESTION.

6. Do they have a bleeding disorder or are they on anticoagulation therapy? Yes ☐ No ☐

If yes, they can still get a vaccine if they have a bleeding disorder or take anticoagulation medicines. But tell their vaccinator about their condition. If no, GO TO NEXT QUESTION.

7. Have they ever had mastocytosis (rare condition caused by an excess number of mast cells gathering in the body's tissues)? Yes ☐ No ☐

If yes, they can still get the vaccine, BUT, they should be observed for 30 minutes after they are vaccinated. If no or yes, GO TO NEXT QUESTION.

8. Have they had a previous COVID-19 infection? Yes ☐ No ☐

If yes and they have been vaccinated against COVID-19 previously then they should wait at least 3 months since their last infection or vaccine before getting vaccinated.

If yes and receiving a first ever 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 4 weeks since they tested positive or developed symptoms.

If no, GO TO NEXT QUESTION.

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Complete this section if they are getting a second or third dose of a COVID-19 vaccine after their first dose because they have a weak immune system (immunocompromise)

9. 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 9a.

If no, GO TO QUESTION 10.

9a. Has it been at least 4 weeks since their 1st dose of the vaccine? Yes ☐ No ☐

If yes, GO TO QUESTION 9b. If no, they should wait at least 4 weeks since their last dose.

9b. 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

10. 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 10a. If no, GO TO NEXT SECTION.

10a. If yes, has it been at least 4 weeks since their last COVID-19 vaccine dose? Yes ☐ No ☐

If yes, go to question 10b.

If no, they should wait at least 4 weeks since the last COVID-19 vaccine

10b. 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

Please complete the following questions if the person is pregnant

Please note: mRNA COVID-19 vaccines are the recommended vaccines in pregnancy. There is less information on the use of Nuvaxovid in pregnancy. They should be advised to discuss the risks and benefits of the vaccine with their treating healthcare professional.

11a. Have they already had a COVID-19 vaccine in this pregnancy? Yes ☐ No ☐

If yes, they should be informed that usually in pregnancy, only one dose is offered. However, if they are pregnant and immunocompromised, a second dose of the vaccine may be considered if it has been more that 6 months since their last vaccine or infection. They should speak to their healthcare provider.

If no, GO TO QUESTION 11b.

11b. Have they had COVID-19 infection or a COVID-19 vaccine in the last 6 months? Yes ☐ No ☐

If yes, they should wait at least 6 months from their last COVID-19 infection or COVID-19 vaccine dose to get vaccinated

Please note that the interval between last infection or last vaccination is different in pregnancy. If eligible, a COVID-19 vaccine can be given at any time in pregnancy but ideally should be given between 20 and 34 weeks of pregnancy.

Vaccination may proceed if no issues for further investigation, deferral or contraindications are noted in the above questions.

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PART 3: VACCINATION CONSENT

For people aged 16 years and older

One of these options 1-3 is appropriate when establishing consent (please tick as appropriate)

1. The individual has consented to vaccination with COVID-19 vaccine (Nuvaxovid) and has been provided with written information,
   OR ☐
2. The individual does not consent to having a COVID-19 vaccine (Nuvaxovid), and should not be vaccinated,
   OR ☐
3. The individual cannot consent and they are being vaccinated with COVID-19 vaccine (Nuvaxovid) according to their benefit and will and preference, **AND** ☐
   The above is recorded in their healthcare record and includes information about any consultation that has taken place to help determine their will and preference. ☐

Name (Please print) | | | | | | | | | | | | | | | | | | | |

Signature _____ Date D D M M Y Y Y Y

For people aged 15 years and younger

Medical Consent: Please note only a parent or legal guardian can provide consent for a medical procedure, or refuse consent for a medical procedure for young people under 16 years of age. Young people aged 16 years or older are legally entitled to consent for themselves. Read more about the HSE Consent Policy on the HSE website.

By signing the below I confirm that:

1. I am authorised to give consent on behalf of the above named child/young person.
2. I understand that I am giving consent for the administration of a dose of a COVID-19 vaccine (Nuvaxovid)
3. I have read and understand the accompanying vaccine information, including known side effects

Name (Please print) | | | | | | | | | | | | | | | | | | | |

Signature _____ Date D D M M Y Y Y Y

Please tick Parent ☐ Legal Guardian ☐

This young person assents to receiving the vaccine (Please tick) ☐

Thank you for completing the consent form. Please return it to your vaccinator.

Privacy Notice: The HSE do not use consent as a lawful basis for processing personal data. In the interest of transparency, to explain how we collect and use personal information the HSE provides details within the HSE Privacy Notice for Patients and Service Users **(https://www.hse.ie/eng/gdpr/hse-data-protection-policy/hse-privacynotice-service-users.pdf)** which is accessible via the HSE Privacy Statement **(https://www2.hse.ie/privacy-statement/)**. The processing of your / your child's data will be lawful and fair. It will only be processed for specific purposes including, to manage the vaccinations, to report and monitor vaccination programmes, to validate clients and provide health care. Data sharing between HSE departments may also occur.

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COVID-19 Vaccine - the latest Nuvaxovid antigenically updated vaccine available												
Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Batch No.	Expiry Date				Vaccination Site	Date Given			
			D	D	M	M	right deltoid ☐	D	D	M	M
			Y	Y	Y	Y	left deltoid ☐	Y	Y	Y	Y

Completed by:		MCRN/PIN:	

Date:	D	D	M	M	Y	Y	Y	Y

If vaccine not administered please state why?

- ☐ DNA or Absent
- ☐ Refused on the Day
- ☐ Vaccine Contraindicated
- ☐ Deferred
- ☐ Other

For official use only

Notes/Comments: