COVID-19 Vaccination Consent Form for 12 – 15 year olds

COVID-19 VACCINE Public Health Advice

Please note only a parent or legal guardian can consent or refuse consent for young people aged 12-15 years of age. Read more about consent on the HSE website https://bit.ly/ConsentU16.
Young people aged 16 years or older are legally entitled to consent for themselves.

The young person will also be asked by their vaccinator whether they agree to being vaccinated.

Consent to vaccination covers the course of two doses of vaccine over about a month.

Section 1: Personal Details

Complete this part for the young person (PLEASE USE BLOCK CAPITALS)

Young Person's Forename:

Young Person's Middle Name:

Young Person's Surname (Family Name):

Otherwise known as:

Young Person's Personal Public Service Number (PPSN):

Young Person's Date of Birth DD/MM/YYYY

Gender (please circle) Male Female

Mother's Maiden Name:

Young Person's Address:

Eircode: County:

Parent/Legal Guardian Forename and Surname:

Parent/ Legal Guardian Mobile Phone Number:

Parent/Legal Guardian Email Address:

I acknowledge that the young person's information will be processed by the HSE in accordance with the GDPR and data Protection acts. (Tick the box)

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Young Person's Name:

Please answer the following questions with a yes or no answer

1. Has this young person ever had a serious allergic reaction (anaphylaxis) that needed medical treatment:
I) after having a previous dose of the Moderna (Spikevax®) or Pfizer/BioNTech (Comirnaty®) COVID-19 vaccine, OR
II) to any of the vaccine ingredients, including polyethylene glycol known as PEG?
If yes, they cannot get this vaccine. If no, GO TO NEXT QUESTION.

Yes ☐ No ☐

1b. Have they ever had a serious allergic reaction (anaphylaxis) to Trometamol (a contrast dye used in MRI radiological studies)?
If yes, they cannot get the Moderna (Spikevax®) vaccine. But they can have a different vaccine. Talk to your GP. If no, GO TO NEXT QUESTION.

Yes ☐ No ☐

2. Have they ever had a serious allergic reaction (anaphylaxis):
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 a medicine that contains polyethylene glycol (PEG), OR
III) for unexplained reasons. This may mean they are allergic to polyethylene glycol (PEG)?
If yes, they cannot get this vaccine, you may need specialist advice. If no, GO TO NEXT QUESTION.

Yes ☐ No ☐

3. Have they ever had:
I) Mastocytosis (rare condition caused by an excess number of mast cells gathering in the body's tissues) OR
II) idiopathic anaphylaxis. This is a serious allergic reaction (anaphylaxis) with no known cause. OR
III) a serious allergic reaction (anaphylaxis) due to food, medication or venom from an insect or animal?
If yes, they can still get the vaccine, BUT, they should be observed for 30 minutes after they are vaccinated. GO TO NEXT QUESTION. If no, GO TO NEXT QUESTION.

Yes ☐ No ☐

4. Have they had myocarditis (inflammation of the heart muscle) after having a previous dose of the Moderna (Spikevax®) or Pfizer/BioNTech (Comirnaty®) COVID-19 vaccine?
If yes, they cannot get this vaccine. If no, GO TO NEXT QUESTION.

Yes ☐ No ☐

5. Have they had pericarditis (inflammation of the lining around the heart) after having a previous dose of the Moderna (Spikevax®) or Pfizer/BioNTech (Comirnaty®) COVID-19 vaccine?
If yes, GO TO QUESTION 5b. If no, GO TO NEXT QUESTION.

Yes ☐ No ☐

5b. Since they had pericarditis (inflammation of the lining around the heart) after a previous dose of the Moderna (Spikevax®) or Pfizer/BioNTech (Comirnaty®) COVID-19 vaccine, a specialist doctor must approve they get this vaccine. Has their COVID-19 vaccination been approved by a specialist doctor?
If yes, GO TO NEXT QUESTION. If no, they cannot get this vaccine.

Yes ☐ No ☐

6. Have they tested positive for COVID-19 within the last 4 weeks?
If yes, 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, or 4 weeks from their first positive PCR test if they did not have symptoms.

Yes ☐ No ☐

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Young Person's Name:

Please answer the following questions with a yes or no answer

7. Does this young person 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.

8. Only answer if this young person is female. Are they pregnant? Yes ☐ No ☐
If yes, go to 8b.

8b. Have they talked to their Obstetrician, Midwife or Doctor about the risks and benefits of getting the vaccine? Yes ☐ No ☐
If yes, they can be vaccinated today
If no, they should discuss with their Obstetrician, Midwife or Doctor first. They cannot be vaccinated today.

Choose Section 2 (YES) or Section 3 (NO) ☐

Section 2 Please tick each box and sign to say YES ☐

- I have read and understand the vaccine information including the known side effects
- I understand that I am giving consent for the administration of two doses of COVID-19 vaccine over approximately one month ☐
- I confirm that I am authorised to give consent on behalf of the above named young person ☐
- **YES**, I consent to the above named young person to receive the COVID-19 vaccine

Signature: Date: DD/MM/YYYY

Name (Please print):

(Please tick): Parent ☐ Legal Guardian ☐

OR

Section 3 Please tick each box and sign to say NO

- I have read and understand the accompanying vaccine information, including known side effects.
- I confirm by signing this form that I am authorised to refuse consent on behalf of the above named young person.
- NO, I do not consent to the vaccination of the above named young person with COVID-19 vaccine.

Signature: Date: DD/MM/YYYY

Name (Please print):

(Please tick): Parent ☐ Legal Guardian ☐

Reason for Refusal:

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Young Person's Name:

FOR OFFICE USE ONLY

DOSE 1

This Young person assents to receiving the vaccine ☐

DOSE 1 – COVID-19 Vaccine		Name of vaccine			
Date Given	Batch Number	Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN	Injection Site (Circle as appropriate)	
				Right Deltoid	Left Deltoid
Time Vaccinated: AM/PM		Vaccination Location			

Completed by: **MCRN/PIN: (if applicable)**

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**

DOSE 2

This Young person assents to receiving the vaccine ☐

DOSE 2 – COVID-19 Vaccine		Name of vaccine			
Date Given	Batch Number	Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN	Injection Site (Circle as appropriate)	
				Right Deltoid	Left Deltoid
Time Vaccinated: AM/PM		Vaccination Location			

Completed by: **MCRN/PIN: (if applicable)**

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**

Notes/Comments: