COVID 19
Vaccination consent form for children and young people

The COVID-19 vaccine is being offered to your child. After your child receives their first COVID-19 vaccine you may be notified about the second dose later. Please discuss the vaccination with your child, then complete this form before it is due. 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 person signing the consent form:

Postcode:

NHS number (if known):

Ethnicity:

School (if relevant):

Year group/class:

GP name and address:

Consent for COVID-19 vaccination (Please complete one box only)

I want my child to receive: First Covid Vaccine: ☐ Second Covid Vaccine: ☐ I don't know ☐ Name of child:	I do not want my child to have the COVID-19 vaccine Name of child: Please describe the reason(s) for not consenting to receive the Covid-19 Vaccination
Name of person signing the form: Signature: Date:	Name of person signing the form: Signature: Date:
Do you have parental responsibility:	Do you have parental responsibility:

Checklist for children aged 12 to 15 years being vaccinated in schools: Pfizer BioNTech Covid-19 Vaccine

Please complete the following checklist for your child. If you tick yes to any of the answers below, your school immunisation team will contact you for further information. Please let the school immunisation team know if anything changes prior to the date of your child's Covid immunisation session

Has your child	If yes, please tick	If you ticked the box, please provide further details
Ever had a Covid vaccine before? (For example as part of a trial, or because they are in an at risk group)		What date(s)? Did they have any reaction or adverse events?
Had an illness with a temperature (fever) in the last week?		If yes, please give details
Had any other vaccines in the last 7 days?		If yes, please give details
Got any long-term medical conditions that require on-going hospital treatment or are they waiting to see a specialist?		If yes, please give details
Had a positive Covid test in the last 12 weeks?		If yes, what date(s)?
Ever had to go to hospital following a severe allergic reaction?		If yes, please give details
Have any blood clotting disorders?		If yes, please provide details
Is your child taking any blood thinning medication e.g. aspirin		If yes, please give details

Please enter your signature and name below to declare that you have completed the pre-screening checklist on behalf of your child.

Signature: Date:

Full name of person signing consent form:

Please read the What to expect after your COVID-19 vaccination leaflet at gov.uk/governmentpublications/ covid-19-vaccination-resources-for-children-and-vounq-people. It will tell you about the side effects and how to report them to the yellow card scheme at yellowcard.mhra.gov.uk

Office Use Only

Date of COVID - 19 vaccination	Site of injection please circle	Batch number / expiry date	Name of immuniser (Please print)	Where administered (hub, PCN, GP etc)
First	Left arm	Right arm		
Second	Left arm	Right arm		