

Reception/office use only:

ID checked: ☐Form checked: ☐

COVID 19 Vaccine AstraZeneca

Royal Papworth Hospital
NHS Foundation Trust

Health/Social Care Workers

Consent to COVID-19 Immunisation Dose 1

SECTION ONE. Complete in BLOCK CAPITALS:**Illegible writing** may affect the accuracy of your record, ALL WRITING MUST BE CLEAR OR TYPED

Surname:	NHS Number:(REQUIRED) Check a prescription, NHS Card, hospital letter. Enter in boxes below:		
First Name:	Post Code:		
Date of Birth:	Age:		
Job Title:			
Employment Type:	Ethnicity:		
	Department/Ward Working In:		
	Are you prone to Fainting? Yes No		
Are you in a Covid risk group: Yes No Not Known <small>If Yes, What Group:</small>			
Gender:			

SECTION Two. Which Organisation do you work for?**SECTION THREE. Are you frontline staff****YES:** Patient facing (Clinical staff or administrative staff working in a clinical area such as an Outpatient Receptionist, nurse, HCA, AHP etc.).**SOMETIMES:** Interact with patients directly or indirectly, brief exposure to patients occasionally in Your role (e.g. Students, engineers, carpenters etc.).**NO NEVER:** Never see patients face to face (e.g. admin role in an office with no patient interaction, including areas like Finance, IT, legal services, library services, catering, domestic services and gardeners).**SECTION FOUR. Answer ALL of the following questions:**

1. Are you under 18 years of age?	
2. Are you currently unwell with a high temperature and/or acute infection?	
3. Do you have any current health problems affecting your immune system or a bleeding disorder?	
4. Do you currently receive medication that affects your immune system e.g. corticosteroids (not inhaled), cytotoxic drugs or radiotherapy, or receiving anticoagulation therapy?	
5. Have you received any vaccines IN THE 7 DAYS (including Flu vaccine)? If YES, what and when did you receive it?	
6. Are you pregnant, breast feeding or planning/currently trying to conceive (in next 3 months)?	
7. Do you have any allergies that have resulted in anaphylaxis or hospital admission?	
8. Have you had a confirmed anaphylactic reaction to any of the following vaccine excipients: L-histidine, L-histidine hydrochloride monohydrate, magnesium chloride hexahydrate, polysorbate 80, ethanol, sucrose, sodium chloride, disodium edetate dihydrate, water for injections.	
9. Do you have any other allergies or medical conditions that the vaccinator should be aware of? If YES, please detail in comments box below.	

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10. Have you taken part in any of the Covid Vaccine trials?	
11. Have you had a positive Covid-19 swab/test in the past 4 weeks? If YES, what date did you receive a positive result?	
12. Have you previously received a dose of the Covid-19 vaccine? If YES which one and when did you have this?	
Comments (Please use this section to provide more information from any responses above):	

SECTION FIVE. Declaration:

I have read the supplementary vaccine information sheet and declare to the best of my knowledge the above information is true and I consent to vaccination against COVID-19 disease caused by SARS-CoV-2 virus. I understand my immunisation details will be held on my RPH patient record, a centralized computer system (NIVS) and will be made available to my employer. **I am a woman of childbearing age and I have read the leaflet on pregnancy and breastfeeding.** ☐

Client Signature:

Date:

VACCINE DETAILS: ***For VACCINATOR to complete only***

Date of 1 st Dose of Vaccine Given date:		
Vaccine Name:		
Batch Number:	(insert sticker)	
Expiry Date:		
Defrost Expiry Date & time:		
Diluent: (NaCl) Sodium chloride (CIRCLE which applies)	Batch number:	Expiry:
Route of Administration (CIRCLE which applies):	Intramuscular	
Site of Vaccination (CIRCLE which applies):	Left Deltoid / Right Deltoid	Left Anterolateral Thigh / Right Anterolateral Thigh
VACCINATOR DETAILS:		
Print name:	Signature:	