Reception/office use only:
ID checked: ☐
Form checked: ☐
V1.2

COVID 19 Vaccine AstraZeneca

Health/Social Care Workers

NHS
Royal Papworth Hospital
NHS Foundation Trust

Consent to COVID-19 Immunisation Dose 2

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

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 (tick correct):

- Additional Clinical Services ☐
- Additional Professional and Technical Services ☐
- Admin and Clerical ☐
- AHP (e.g. Physio) ☐
- Ambulance Service ☐
- Care Home Worker ☐
- Estates and Ancillary ☐
- Healthcare Assistants ☐
- Healthcare Scientists ☐
- Medical and Dental ☐
- Not Known ☐
- Nursing and Midwifery ☐
- Other ☐
- Social Care Worker ☐
- Student Doctor ☐
- Student Nurse ☐

Employment type (Please tick the relevant box):
NHS: Permanent ☐ Fixed term ☐ Student ☐
NHS: Bank/Agency ☐ Honorary ☐ Contractor ☐
Care Home Staff: Permanent ☐ Fixed term ☐
Other: ☐ Please specify: _____
Not Applicable: ☐

Ethnicity:
See back page for options:

Department/Ward working in:

Are you prone to Fainting? Yes / No

Are you in a Covid risk group (circle correct answer): Yes / No / Not known
If Yes, what group:

Pregnant ☐ **Chronic respiratory disease** ☐ **Chronic heart disease** ☐
Diabetes ☐ **Chronic liver disease** ☐ **Chronic kidney disease** ☐
Morbid Obesity ☐ **Learning Disability** ☐ **Chronic neurological disease** ☐ **Due to Age** ☐
Splenic Dysfunction or asplenia ☐ **Weakened immune system** ☐ **Not Known** ☐

Gender (circle selected option): **Male** **Female** **Indeterminate** **Non-Binary** **Prefer not to say**

SECTION Two. Which Organisation do you work for?

Royal Papworth Hospital staff (RPH- including Bank, OCS)	
Cambridge and Peterborough Foundation Trust (CPFT)	
Cambridge University Hospitals Trust (CUH- including Bank, students, Honorary contracts)	
Each	
England Ambulance Service NHS Trust (EEAST)	
Cambridgeshire Community Services NHS Trust (CCS)	
Clinical Commissioning Groups (CCGs)	
Arthur Rank Hospice	
Clinical School (Med students, Doctors, Nurses, AHPs with a clinical place)	
Care Home (please state the name of Care Home):	
Other Health Worker. Please specify:	

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).	

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SECTION FOUR. Answer ALL of the following questions:	
1. Are you **under 18** years of age**?**	**YES/NO**
2. Are you currently unwell with a high temperature and/or acute infection?	**YES/NO**
3. Do you have any current health problems affecting your immune system or a bleeding disorder?	**YES/NO**
4. Do you currently receive medication that affects your immune system e.g. corticosteroids (not inhaled), cytotoxic drugs or radiotherapy, or receiving anticoagulation therapy?	**YES/NO**
5. Have you received any vaccines IN THE 7 DAYS (including Flu vaccine)? **If YES**, what and when did you receive it?.....	**YES/NO**
6. Are you pregnant, breast feeding or planning/currently trying to conceive (in next 3 months)?	**YES/NO**
7. Do you have **any allergies that have resulted in anaphylaxis** or hospital admission?	**YES/NO**
8. Have you had a ***confirmed anaphylactic reaction*** to: One dose (0.5 ml) contains: COVID-19 Vaccine (ChAdOx1-S* recombinant) 5 × 1010 viral particles * Recombinant, replication-deficient chimpanzee adenovirus vector encoding the SARS-CoV-2 Spike glycoprotein. Produced in genetically modified human embryonic kidney (HEK) 293 cells. This product contains genetically modified organisms (GMOs). The other excipients are L-histidine, L-histidine hydrochloride monohydrate, magnesium chloride hexahydrate, polysorbate 80, ethanol, sucrose, sodium chloride, disodium edetate dihydrate, water for injections.	**YES/NO**
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.	**YES/NO**
10. Have you taken part in any of the Covid Vaccine trials?	**YES/NO**
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……..	**YES/NO**
12. Have you ever suffered with major thrombosis (blood clots) associated with thrombocytopenia (low platelets)? This includes previous blood clots associated with AstraZeneca COVID-19 vaccination and heparin induced thrombocytopenia (HIT)	**YES/NO**
13. Do you have a history of Cerebral Venous Sinus Thrombosis (CVST), acquired or genetic thrombophilia or anti-phospholipid syndrome?	**YES/NO**
14. Have you previously received a dose of the Covid-19 vaccine? **If YES**, which one and when did you have this……	**YES/NO**
Comments (Please use this section to provide more information from any responses above):	**YES/NO**

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 2nd Dose of Vaccine Given date:		
Vaccine name:		
Batch number:	***(insert sticker)***	
Expiry date:		
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:**	

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THIS SHEET DOES NOT NEED TO BE RETAINED AS PART OF THE CONSENT FORM.
To be used to complete the Ethnicity box on the front page of the consent form

Ethnicity Options:-

WHITE
- British
- Irish
- Any other white background

MIXED
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background

OTHER ETHNIC GROUPS
- Chinese
- Any other ethnic group
- Patient chose not to provide this information

BLACK OR BLACK BRITISH
- Caribbean
- African
- Any other Black background

ASIAN OR ASIAN BRITISH
- Indian
- Pakistani
- Bangladeshi
- Any other Asian background