Reception/office use only:
ID checked: ☐
Form checked: ☐

V.1.2

COVID 19 Vaccine AstraZeneca

NHS
Royal Papworth Hospital
NHS Foundation Trust

Health/Social Care Workers

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 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: Please Select An Item	
Employment Type: Please Select An Item	**Ethnicity:** Please Select An Item
	Department/Ward Working In:
	Are you prone to Fainting? Yes ☐ No ☐
Are you in a Covid risk group: Yes ☐ No ☐ Not Known ☐ **If Yes, What Group:** Please Select An Item	
Gender: Please Select An Item	

SECTION Two. Which Organisation do you work for?
Please Select An Item

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**?**	Select
2. Are you currently unwell with a high temperature and/or acute infection?	Select
3. Do you have any current health problems affecting your immune system or a bleeding disorder?	Select
4. Do you currently receive medication that affects your immune system e.g. corticosteroids (not inhaled), cytotoxic drugs or radiotherapy, or receiving anticoagulation therapy?	Select
5. Have you received any vaccines **IN THE 7 DAYS** (including Flu vaccine)? **If YES**, what and when did you receive it?	Select
6. Are you pregnant, breast feeding or planning/currently trying to conceive (in next 3 months)?	Select
7. Do you have **any allergies that have resulted in anaphylaxis** or hospital admission?	Select
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.	Select
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.	Select

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10. Have you taken part in any of the Covid Vaccine trials?	Select
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?	Select
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)	Select
13. Do you have a history of Cerebral Venous Sinus Thrombosis (CVST), acquired or genetic thrombophilia or anti-phospholipid syndrome?	Select
14. Have you previously received a dose of the Covid-19 vaccine? **If YES** which one and when did you have this?	Select
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 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:**	