Consent Form for children aged 5 - 11 years

COVID-19 mRNA vaccine

Please scan the QR code to access information about your child's vaccine and what to expect. It will also explain how to report suspected side effects or adverse reactions via the Yellowcard scheme. If you require this information in an alternative format, this can be provided by contacting 111 or when you attend your child's appointment.

Child's full name (first name and surname):
Home address:
NHS number (if known):
GP Practice:

Date of birth:	Age
Date of Last Dose:	Last vaccine dose type:

Consent for a Covid-19 Vaccination

I want my child to receive a dose of COVID-19 vaccination
Parent / Carer Name (Legal Guardian):
Relationship to child:
Daytime contact telephone number for parent or carer:
Signature:
Date:

Confirmation of vaccine booked in for:

Please remember to complete the other side of this form

Office use only

Medicine Prescribed	Dose (mcg)	Route	Freq	Date	Vaccine Patient Specific Direction *(for Doctors only)*	Signature	GMC No.
		I / M	Stat	DD / MM / YY			

Date of vaccination	Time	Vaccine Dose (mcg)	Site of injection *(please circle)*				Batch Number	Expiry date	Brand of Vaccine
DD / MM / YY	00 : 00		Left Arm	Right Arm	Left Thigh	Right Thigh		MM / YY	

Immuniser name and signature **(PLEASE PRINT)**	Where administered *(hub etc)*
Clinical Notes:	

manx care
Kiarail Vannin

Manx Care (Primary Care) is committed to protecting your privacy and will only process personal confidential data in accordance with Data Protection Act 2018, the Data Protection (Application of GDPR) Order 2018, the Common Law Duty of Confidentiality and the Human Rights Act 2001 for details visit gov.im/manxcare-privacy.

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Adapted from Manx Care Pfizer Consent Form IMM 102 05/2021 V4

Ref: IMM112d 07/2023 (MC202276)

Eligibility Criteria

PRE-ASSESSMENT QUESTIONNAIRE *(Please circle the following)*

Protecting the staff: if you answer YES to the below you will be assessed by a member of the Vaccination team.		
Is your child currently COVID-19 positive?	**Yes**	**No**
Is your child feeling unwell today or suffering from a high temperature or fever today?	**Yes**	**No**
If you answer **YES** to the next group of questions please inform the clinical staff as **YOU MAY NOT** be able to have the vaccination today		
Has your child had a previous systemic allergic reaction (including immediate onset anaphylaxis) to a previous dose of a COVID-19 vaccination or to any component of the vaccine or residues from the manufacturing process? *(Refer to Product Information Leaflet for a full list of the ingredients)* *(Refer to guidance in Green Book Chapter 14a for administration of a subsequent dose if allergic reaction to first dose.)*	**Yes**	**No**
Does your child have a history of: • *immediate anaphylaxis to multiple, different drug classes, with the trigger unidentified (this may indicate Poly Ethylene Glycol (PEG) allergy);* • *anaphylaxis to a vaccine, injected antibody preparation or a medicine likely to contain PEG (such as depot steroid injection, laxative); or* • *idiopathic anaphylaxis?*	**Yes**	**No**
Has your child experienced myocarditis or pericarditis determined as likely to be related to previous COVID-19 vaccination?	**Yes**	**No**
Has your child experienced Capillary leak syndrome?	**Yes**	**No**
The following questions relate to cautions in relation to the COVID-19 mRNA vaccine. If you have questions please read the information leaflet or discuss with the clinical staff.		
Do they have a condition or receive treatment that severely affects their immune system? If yes, please specify the condition or treatment that affects their immune system below:	**Yes**	**No**
Do they have a bleeding disorder?	**Yes**	**No**
Are they taking any blood thinners?	**Yes**	**No**
Have they experienced Guillain-Barre Syndrome (GBS) following a COVID-19 vaccination?	**Yes**	**No**
Are they participating in a clinical trial of COVID -19 vaccines? (To be referred back to trial investigators for approval before vaccinating)	**Yes**	**No**
I can confirm that I have been given access to a copy of the Patient Information Leaflet (PIL)	**Yes / QR code provided**	**Declined**