

# COVID-19 School Vaccination (Dose 1) Consent Form

From aged 12 years, School Years 7-13 inclusive



Please complete and return this form to school by Friday 26th November. (This will save your child's school having to contact you). Complete a separate form for each child.

Pupil's name:	Pupil's DOB (dd/mm/yyyy):
School name:	Form/Year group:
GP Practice Name:	
Daytime telephone numbers (parent/ young person 16+):	
Email address:	
Pupils's Social Security Number:	

Please read leaflets emailed to you 19<sup>th</sup> November 2021 and answer all questions below (tick as appropriate)

Contraindication questions:	Yes	No
Have you had a positive PCR COVID test in the past 12 weeks? If Yes, please provide date:	Date:	
Have you ever had a COVID-19 Vaccine before?		
Have you ever had anaphylaxis / severe allergic reaction to anything?		

<b>YES</b> - I want my child to have Dose 1 of the COVID-19 Vaccine at school (12-15yrs only) <b>OR</b> <b>YES</b> - I am 16 years or over and I am signing for myself to have the COVID-19 vaccine at school		<b>NO</b> - I do not want my child to have the COVID-19 Vaccine at school (12-15yrs only) <b>OR</b> <b>NO</b> - I am 16 years or over and I do not consent to have the COVID-19 vaccine at school	
Parent / Guardian's Name (with parental responsibility) or Student 16yrs +		Parent / Guardian's Name (with parental responsibility) or Student 16yrs +	
Relationship to child (please select): (12-15 yrs only)		Relationship to child (please select): (12-15 yrs only)	
Signature: (please type name)		Signature: (please type name)	
Date (dd/mm/yyyy):		Date (dd/mm/yyyy):	

## FOR OFFICAL USE ONLY

Batch number:	Expiry Date: (dd/mm/yyyy):	Date given: (dd/mm/yyyy):
Vaccine administered by (print name):	Venue (if diff from school name above):	Site given: