2023 Flu and COVID-19 vaccination **consent form**

Person

Surname _____ First name _____

Phone _____ Date of birth ___/___/_____ Age _____ years
DD MM YYYY

Address _____

Medical Centre/GP _____ NHI _____
National Health Index number if known

Ethnicity (please tick one or more)

☐ NZ European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean

☐ Chinese ☐ Indian ☐ Other – please state _____

Consent statements

- ☐ I have read the vaccination fact sheets provided for the flu and COVID-19 vaccines.
- ☐ I confirm that I/ the person being vaccinated has not tested positive for COVID-19 or received a COVID-19 vaccination in the last 6 months.
- ☐ I understand I will need to wait at least 15 minutes after the vaccination.
- ☐ The benefits and risks of the flu and COVID-19 vaccines have been explained to me.
- ☐ The common and rare side effects of the flu and COVID-19 vaccines have been explained to me.
- ☐ I had enough time to ask questions and my questions were answered to my satisfaction.
- ☐ I have received or photographed the fact sheets so I can refer to them after my vaccination.
- ☐ I was told how and when to seek assistance if I/ the person being vaccinated experience symptoms that may be vaccine related.
- ☐ The vaccinator has discussed with me other vaccines that I am eligible for.
- ☐ I understand this vaccination information will be recorded and shared with my/the vaccinated person's regular healthcare provider.
- ☐ **I consent to the flu and COVID-19 vaccinations being given.**

Signature _____ Date ___/___/_____
DD MM YYYY

As parent / legal guardian / enduring power of attorney

I _____ am the parent, legal guardian or enduring power of attorney, and agree to the flu and COVID-19 vaccination of the person named above.

Relationship to person being vaccinated _____ Phone _____

Signature _____ Date ___/___/_____
DD MM YYYY

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New Zealand Government

Mā tātau katoa e ārai atu te COVID-19

Te Whatu Ora
Health New Zealand

Vaccination record (for vaccinator use)

Consumer details confirmed ☐ Affirmative answer to any screening questions? ☐ Yes ☐ No

If yes, record the detail and advice given _____

Verbal and written post vaccination information given ☐ Other vaccines discussed ☐

Informed consent obtained? ☐ Yes ☐ No

☐ Confirmed 6 months since last dose of COVID-19 vaccine.

☐ If the COVID-19 vaccine dose is being administered off label or off Programme recommendations, a prescription has been supplied by an authorised prescriber and will be uploaded to the CIR.

COVID-19 vaccination details

Name of vaccine	Batch	Expiry	Dose	Site	Date	Time
Pfizer Comirnaty (15/15mcg) Original/ Omicron BA.4/5 16+ years for those eligible*			0.3mL	Deltoid ☐ L ☐ R		
Novavax Nuvaxovid 18+ years for those eligible			0.5mL	Deltoid ☐ L ☐ R		
Date of last COVID-19 vaccine ___/___/_____						

* Those 12-15 years that meet severely immunocompromised criteria are recommended for an additional dose. This will require a prescription.

Flu vaccination details

Name of vaccine	Batch	Expiry	Dose	Needle size	Site	Date	Time
(write vaccine name or place vaccine sticker here)					Deltoid ☐ L ☐ R		
☐ Funded ☐ Non-funded							

Vaccinator information

Place of vaccination _____

_____

Name _____

Signature _____

Observation period

☐ Details of any AEFI or observations recorded

☐ CARM report completed

Signature _____

Departure time _____

Clinical supervisor*

Name _____

Signature _____

* if relevant

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