COVID-19 vaccination consent form

Full name (first and second name):

CHI number:	Date of birth:
Care home address:	Ethnicity:
GP Practice name and address:	Sex (circle as appropriate): Male Female

Care Home Resident (able to consent for themselves)

Consent for COVID-19 vaccination (please complete one box only on the day of vaccination)

I want to receive the COVID-19 vaccination.	I do not want to accept the COVID-19 vaccination offer.
Name	Name
Signature	Signature
Date	Date

Care Home Resident (not able to consent for themselves)

I consent to the administration of the COVID-19 vaccination.	I do not consent to accept the COVID-19 vaccination offer.
If consent is taken in person by Power of Attorney or Guardian	If offer is declined in person by Power of Attorney or Guardian
Name of Power of Attorney or Guardian	Name of Power of Attorney or Guardian
Signature of Power of Attorney or Guardian	Signature of Power of Attorney or Guardian
Date	Date
If consent is taken verbally e.g. telephone	If refusal is taken verbally e.g. telephone
Name of Power of Attorney or Guardian	Name of Power of Attorney or Guardian
Name of staff member taking consent	Name of staff member taking refusal
Date and time consent taken	Date and time refusal taken

For official use only

	Date of vaccination.	Site of the injection (please circle)		Batch number and expiry date.	Brand of vaccine.	Vaccinator name.	Vaccinator signature.	VMT updated.
COVID-19		L arm	R arm					

Section 47 certificate in place. (Yes or No)		Treatment plan in place. (Yes or No)	