

COVID-19 vaccination consent form

Full name (first and second name):

CHI number:

Care home address:

GP Practice name and address:

Date of birth:

Ethnicity:

Sex (circle as appropriate): Male Female

Resident with capacity to consent to this vaccination

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

I want to receive the COVID-19 vaccination.

Name

Signature

Date

I do not want to accept the COVID-19 vaccination offer.

Name

Signature

Date

Resident without capacity to consent to this vaccination.

I consent to the administration of the COVID-19 vaccination.

If consent is taken in person by Power of Attorney or Guardian

Name of Power of Attorney or Guardian

Signature of Power of Attorney or Guardian

Date

If consent is taken verbally e.g. telephone

Name of Power of Attorney or Guardian

Name of staff member taking consent

Date and time consent taken

I do not consent to accept the COVID-19 vaccination offer.

If offer is declined in person by Power of Attorney or Guardian

Name of Power of Attorney or Guardian

Signature of Power of Attorney or Guardian

Date

If refusal is taken verbally e.g. telephone

Name of Power of Attorney or Guardian

Name of staff member taking refusal

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.
		L arm	R arm					
COVID-19								

Section 47 certificate in place. (Yes or No)

Treatment plan in place. (Yes or No)