

Care Home COVID-19/Flu Vaccination Record of Consent Form

Care Home Resident's Personal Details			
Full name (first and surname):			
CHI number:		Date of birth:	
Care Home:			

Statement of the individual seeking and recording consent decision			
I confirm that an Important information about COVID-19 vaccination leaflet and the Important information about Flu vaccination leaflet have been provided to the resident and/or the resident's Welfare Power of Attorney/Guardian, and that an opportunity has been given to discuss and answer any questions with them before a decision was made.			
Name:		Job title:	
Signature:		Date:	

SECTION A – RESIDENT WITH CAPACITY			
I want to have the COVID-19 vaccination		☐	
I want to have the Flu (influenza) vaccination		☐	
Print full name:			
Signature:		Date:	
If the resident is unable to sign but has communicated consent, a witness should sign below			
Signature:		Date:	
Print full name:			
Job role:			
Method by which consent was communicated:			

SECTION B – RESIDENT WITH INCAPACITY					
I give consent on behalf of the resident for them to receive the COVID-19 vaccination					☐
I give consent on behalf of the resident for them to receive the Flu vaccination					☐
Name of Welfare POA/Welfare Guardian:					
Signature:		Date:		Time:	
If the Welfare POA/Guardian is not present, please state how and when consent was given:					
Telephone ☐	Email ☐	Other:	Date:	Time:	

Statement of the interpreter (where appropriate)

I have interpreted/communicated the COVID-19 vaccination information and the Flu (influenza) vaccination information above to the resident/person with welfare guardianship or POA (delete as appropriate) to the best of my ability, and in a way in which I believe was understood.

Name:**Signature:****Or telephone interpreter ID number:****Date:****For official use only**

	Date of vaccination	Site of injection (circle)		Batch No/ expiry date	Brand of vaccine	Vaccinator name [print]	Vaccinator signature	VMT updated
COVID-19		L arm	R arm					
FLU		L arm	R arm					

Section 47 certificate in place?

Yes ☐No ☐

Treatment plan in place?

Yes ☐No ☐