Parent/Guardian to complete

**COVID-19**

**Vaccination consent form for 5 - 11 year old**

The COVID-19 vaccine is being offered to your child. Information on the vaccines can be found at [COVID-19 vaccination: resources for children and young people - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/covid-19-vaccination-resources-for-children-and-young-people). Please discuss the vaccination with your child, and then complete this form before it is due. Information about the vaccinations will be put on your child’s health record.

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| **Student details** | | | |
| Surname: | First name: | | |
| Date of birth: | Ethnicity: | | School and class: |
| NHS number: | Gender: | |
| Home address:  Post code: | Day time contact number: | | GP name and address: |
|  | | | |
| Has your child had a positive COVID test? **(If your child has had a positive COVID test please state date)** | | | |
| Has your child had a COVID vaccination?  **If yes please give us a date to ensure the correct gap between 1st and 2nd dose.** | | | |
| Has your child had a severe allergic reaction to any injection or medication? ***(needing hospital care)*** | | | |
| \*If you answered **Yes** to any of the above, please give details: | | | |
| Ask for the ‘What to expect after your COVID-19 vaccination leaflet at [COVID-19 vaccination: resources for children and young people - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/covid-19-vaccination-resources-for-children-and-young-people). It will tell you about the side effects and how to report them to the Yellowcard scheme at yellowcard.mhra.gov.uk | | | |
| **Consent for immunisation (please tick YES or NO)** | | | |
| **YES,** I consent for my child to receive the COVID-19 immunisation. | | **NO,** I DO NOT consent to my child receiving the COVID-19 immunisation. | |
| If after discussion, you and your child decide that you do not want them to have the vaccine; it would be helpful if you would give the reason: | | | |
| Signature of parent/guardian  *(with parental responsibility):* | | | Date (DD/MM/YYYY) |

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| **FOR OFFICE USE ONLY 1st COVID Vaccine** |  |  |
| **Vaccine details**    Date: Time:      Right Deltoid Left Deltoid      **Administered by**  Name, designation and signature:    Date: | Batch number: | Expiry date: |

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| **FOR OFFICE USE ONLY 2nd COVID Vaccine** |  |  |
| **Vaccine details**    Date: Time:      Right Deltoid Left Deltoid      **Administered by**  Name, designation and signature:    Date: | Batch number: | Expiry date: |