**Please take this consent form to your vaccination appointment. You may be asked to complete it there.**

COVID-19 vaccination consent form

Health Care Worker

The COVID-19 vaccination will reduce the chance of you suffering from COVID-19 disease. Like all medicines, no vaccine is completely effective and it takes a few weeks for your body to build up protection from the vaccine. Some people may still get COVID-19 despite having a vaccination, but this should lessen the severity of any infection. If you are currently pregnant, planning pregnancy or breastfeeding please read the detailed information at [www.nhs.uk/covidvaccination](https://www.nhs.uk/covidvaccination)

The vaccine cannot give you COVID-19 infection, and two doses will reduce your chance of becoming seriously ill. You will still need to follow the guidance in your workplace, including wearing the correct personal protection equipment and taking part in any screening programmes.

Like all medicines, vaccines can cause side effects. Most of these are mild and short-term, and not everyone gets them. Please read the product information for more details on the vaccine and possible side effects by searching Coronavirus Yellow Card. You can also report suspected side effects on the same website or by downloading the Yellow Card app. Visit [coronavirus-yellowcard.mhra.gov.uk](https://coronavirus-yellowcard.mhra.gov.uk/)

**Office use only**

**Consent for a course of COVID-19 vaccination (please complete one box only)**

Public Health England gateway number 2020345. Product code: COV2020345 V2. JAN 2021

**Date of COVID-19**

**vaccination**

**Site of injection (please circle)**

**Batch number/ expiry date**

**Brand of Vaccine**

**Immuniser name and signature (please print)**

**Where administered (Occupational health clinic, NHS workplace, etc.)**

First

L arm

R arm

Second

L arm

R arm

If, after discussion, you decide that you do not want to have the vaccine, it would be helpful if you would give the reasons for this below/on the back of this form (and return to the provider).

**I do not want to receive the full course of COVID-19 vaccination**

Name

Signature

Date

**I want to receive the full course of COVID-19 vaccination**

Name

Signature

Date

Date of birth:

Daytime contact telephone number:

Ethnicity:

Gender (circle as appropriate):

Male Female Prefer not to say

I am a woman of childbearing age and I have read the leaflet on pregnancy and breastfeeding

Full name (first name and surname):

Home address:

NHS number:

Workplace address:

GP name and address: