COVID-19 Consent & Medical Eligibility

COVID-19 VACCINE Public Health Advice

Complete this part for the person being vaccinated (PLEASE USE BLOCK CAPITALS)

Name:

Date of Birth:

Please answer the following questions with a yes or no answer

1. Has this person ever had a serious allergic reaction (anaphylaxis) that needed medical treatment:
I) after having a previous dose of the Moderna (Spikevax®) or Pfizer/BioNTech (Comirnaty®) COVID-19 vaccine, OR
II) to any of the vaccine ingredients, including polyethylene glycol known as PEG?
If yes, they cannot get this vaccine. If no, GO TO NEXT QUESTION. Yes ☐ No ☐

1a. Have they ever had a serious allergic reaction (anaphylaxis) to Trometamol (an ingredient in contrast dye used in MRI radiological studies)?
If yes, they cannot get the Moderna (Spikevax®) vaccine or Comirnaty 10mcg/dose. But they can have a different vaccine. They should talk to their GP. If no, GO TO NEXT QUESTION. Yes ☐ No ☐

2. Have they ever had a serious allergic reaction (anaphylaxis):
I) after taking multiple different medications, with no reason known for the reaction. This may mean they are allergic to polyethylene glycol (PEG) OR
II) after having a vaccine or a medicine that contains polyethylene glycol (PEG), OR
III) for unexplained reasons. This may mean they are allergic to polyethylene glycol (PEG)?
If yes, they cannot get this vaccine, they may need specialist advice. Talk to the vaccination team. If no, GO TO NEXT QUESTION. Yes ☐ No ☐

3. Have they ever had Mastocytosis (rare condition caused by an excess number of mast cells gathering in the body's tissues)
If yes, they can still get the vaccine, BUT, they should be observed for 30 minutes after they are vaccinated. GO TO NEXT QUESTION. If no, GO TO NEXT QUESTION. Yes ☐ No ☐

4. Have they had myocarditis (inflammation of the heart muscle) after having a previous dose of the Moderna (Spikevax®) or Pfizer/BioNTech (Comirnaty®) COVID-19 vaccine?
If yes, they cannot get this vaccine. If no, GO TO NEXT QUESTION. Yes ☐ No ☐

Question 5 for children aged 5-11 years only

5. Has this child had multisystem inflammatory syndrome also called MIS-C (a rare syndrome usually treated in hospital) after a COVID-19 infection?
If yes, please answer question 5a and 5b Yes ☐ No ☐

5a. Has this child clinically recovered from MIS-C?
If yes, go to question 6. If no this child cannot be vaccinated today. Yes ☐ No ☐

5b. Has it been over 90 days since this child was diagnosed with MIS-C?
If yes, this child can be vaccinated today. If no, this child cannot be vaccinated today Yes ☐ No ☐

6. Have they had pericarditis (inflammation of the lining around the heart) after having a previous dose of the Moderna (Spikevax®) or Pfizer/BioNTech (Comirnaty®) COVID-19 vaccine?
If yes, GO TO QUESTION 6a. If no, GO TO NEXT QUESTION. Yes ☐ No ☐

Answer Questions on Page 2

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Please answer the following questions with a yes or no answer

6a. Since they had pericarditis (inflammation of the lining around the heart) after a previous dose of the Moderna (Spikevax®) or Pfizer/BioNTech (Comirnaty®) COVID-19 vaccine, a specialist doctor must approve they get this vaccine.
Has their COVID-19 vaccination been approved by a specialist doctor?
If yes, GO TO NEXT QUESTION. If no, they cannot get this vaccine.

Yes ☐ No ☐

7. Have they had the monkeypox or smallpox vaccine (Imvanex or Jynneos) in the last 4 weeks?
If yes, they cannot get this vaccine today. They need to wait 4 weeks after getting these vaccines before getting a COVID-19 vaccine.

Yes ☐ No ☐

8. If receiving your first or second dose of a COVID-19 vaccine, have you been diagnosed with COVID-19 (with a PCR or Antigen test) within the last four weeks?
If yes and receiving a first or second dose of a COVID-19 vaccine, you should delay getting a vaccine until you have recovered from COVID-19 and it has been at least four weeks since you tested positive or developed symptoms, or four weeks from your first positive PCR if you did not have symptoms. If no, go to next question.

Yes ☐ No ☐

Yes ☐ No ☐

9. Has this person tested positive (with a PCR or antigen test) for COVID-19 in the last 4 months?
If yes, they should delay getting an additional or booster dose of COVID-19 for 4 months after diagnosis or onset of symptoms. If no, continue to next question

Yes ☐ No ☐

10. Does this person have a bleeding disorder or are they on anticoagulation therapy?
If yes, they can still get a vaccine if they have a bleeding disorder or take anticoagulation medicines. But tell their vaccinator about their condition.

Yes ☐ No ☐

11. Is this person 29 years of age or younger?
If yes, they can be offered a dose of Pfizer/BioNTech (Comirnaty®).
If no, they can be offered either a dose of Moderna (Spikevax®) or Pfizer/BioNTech (Comirnaty®)

Yes ☐ No ☐

12. For <u>Moderna (Spikevax®)</u> only. Has this person ever been diagnosed with capillary leak syndrome?
If yes, go to question 12a.

Yes ☐ No ☐

12a. Has this person had a discussion on the risks and benefits of this vaccine with their GP or specialist doctor and they have approved the vaccine for them?

Yes ☐ No ☐

13. Is this female pregnant and are they attending for a second booster? If yes go to 13a.

13a. Are they under 16 weeks of pregnancy or have they had a first booster in this pregnancy?
If yes, they are not eligible for vaccination. A second booster is recommended for pregnant women at 16 weeks gestation or later for those who have not received a booster vaccine in the current pregnancy.

Yes ☐ No ☐

One of these options is appropriate when establishing consent (please tick as appropriate)

1. The individual has consented to the vaccination for COVID-19 and has been provided with written information, **OR** ☐
2. The individual does not agree with COVID-19 vaccination and should not be vaccinated, **OR** ☐
3. The individual cannot consent and they are being vaccinated for COVID-19 according to their benefit and will and preference, **AND** ☐

The above is recorded in their healthcare record and includes information about any consultation that has taken place to help determine their will and preference.

FOR OFFICE USE ONLY

Name of Vaccinator _____ Registration Number / PIN / MCRN _____