

# COVID-19 School Vaccination (Dose 1) Consent Form

From aged 12 years, School Years 7-13 inclusive



Please complete and return this form to school before the date nurses will be in your child's school to vaccinate (this will save your child's school having to contact you). Complete a separate form for each child

Pupil's name:	Pupil's DOB (dd/mm/yyyy):
School name:	Form/Year group:
GP Practice Name:	
Daytime telephone numbers (parent/ young person 16+):	
Email address:	
Pupils's Social Security Number:	

Please read accompanying leaflet and answer all questions below (tick as appropriate)

Contraindication questions:	Yes	No
Have you had a positive PCR COVID test in the past 12 weeks? If Yes, please provide date:	Date:	
Have you ever had a COVID-19 Vaccine before?		
Have you ever had anaphylaxis / severe allergic reaction to anything?		

**YES** - I want my child to have Dose 1 of the COVID-19 Vaccine at school (12-15yrs only)

**OR**

**YES** - I am 16 years or over and I am signing for myself to have the COVID-19 vaccine at school

**NO** - I do not want my child to have the COVID-19 Vaccine at school (12-15yrs only)

**OR**

**NO** - I am 16 years or over and I do not consent to have the COVID-19 vaccine at school

Parent / Guardian's Name (with parental responsibility) or Student 16yrs +		Parent / Guardian's Name (with parental responsibility) or Student 16yrs +	
Relationship to child (please select): (12-15 yrs only)		Relationship to child (please select): (12-15 yrs only)	
Signature: (please type name)		Signature: (please type name)	
Date (dd/mm/yyyy):		Date (dd/mm/yyyy):	

## FOR OFFICAL USE ONLY

Batch number:	Expiry Date: (dd/mm/yyyy):	Date given: (dd/mm/yyyy):
Vaccine administered by (print name):	Venue (if diff from school name above):	Site given: