Adult Vaccination Consent

Informed consent. The vaccinator fills the treatment details and explains them; the patient or their representative signs.

Clinic and clinician

HOSPITAL OR CLINIC

VACCINATOR NAME

REGISTRATION NO. (MEDICAL COUNCIL)

PATIENT ID / UHID

Patient

PATIENT FULL NAME

EMAIL

DATE OF BIRTH

GENDER

PHONE

Proposed treatment

VACCINE

DOSE NO.

DATE

BRAND AND BATCH NO.

SITE

You will be asked to wait for 30 minutes after the injection so staff can watch for any reaction.

Risks

Every treatment carries some risk. The common and the serious ones for this treatment include:

- Soreness, redness or swelling at the injection site
- Mild fever, tiredness or headache for a day or two
- Fainting soon after the injection
- Severe allergic reaction (very rare)

RISKS SPECIFIC TO THIS PATIENT

Alternatives

- Delaying vaccination
- Not vaccinating, with the risk of the disease

Your health

Are you unwell or feverish today?

◯ No ◯ Yes

Have you had a severe reaction to a vaccine before?

○ No ○ Yes

Are you pregnant or planning pregnancy?

○ No ○ Yes

Do you have a weakened immune system?

○ No ○ Yes

ALLERGIES, CURRENT MEDICINES, OR DETAILS OF ANY "YES"

Consent

EXPLAINED TO ME IN

SIGNED BY

REPRESENTATIVE NAME (IF NOT PATIENT)

RELATIONSHIP

- The vaccinator has explained the treatment, its purpose, risks and alternatives in a language I understand, and answered my questions.
- I understand no result can be guaranteed.
- This consent covers only the treatment described. If an unexpected problem arises during it that puts life or health at immediate risk, the team may do what is needed to deal with it and will explain afterwards.
- I may withdraw this consent at any time before the treatment starts.

☐ I give my consent to the treatment described above.

Patient

SIGNATURE

PRINTED NAME

DATE

Vaccinator

SIGNATURE

PRINTED NAME

DATE