Assessment and consent form for use with the Public Health England Patient Group Direction for COVID-19 mRNA vaccine BNT162b2 (Pfizer/BioNTech) at East Sussex Healthcare NHS Trust Vaccination Hub

First Name		**Surname**	
Date of birth		**Home address and Postcode**	
Phone/Mobile		**Email address**	

Please read and answer the following questions carefully. Information provided will be used to assess your suitability to receive the Covid-19 vaccine.

Are you under 16 years of age?	No ☐	Yes ☐
Do you currently have a severe illness with a high temperature?	No ☐	Yes ☐
Allergy to first dose of COVID-19 mRNA vaccine BNT162b2? Have you had a previous systemic allergic reaction (**including immediate onset anaphylaxis**) to a previous dose of COVID-19 vaccine or to any component of the vaccine? This includes polyethylene glycol (PEG) or to any of the residues from the manufacturing process?	No ☐	Yes ☐
Have you had a **localised urticarial** (itchy) skin reaction (**without systemic symptoms**) to the first dose of a COVID-19 vaccine? Please note that those answering **yes** will need to be **observed for 30 minutes** Those with non-allergic reactions (vasovagal episodes, non-urticarial skin reactions or non-specific symptoms) can receive the second dose as usual.	No ☐	Yes ☐
Do you have a history of **immediate onset-anaphylaxis** to multiple drugs or unexplained anaphylaxis? Please list drugs :	No ☐	Yes ☐
Are you pregnant or think you might be pregnant?	No ☐	Yes ☐
Have you had confirmed Covid-19 infection in the last 4 weeks?	No ☐	Yes ☐
Have you had the flu vaccine in the last 7 days?	No ☐	Yes ☐
Have you had a dose of the covid-19 vaccine in the last 21 days?	No ☐	Yes ☐
Are you taking part in a Covid-19 vaccine trial?	No ☐	Yes ☐
Do you have bleeding problems or a bleeding disorder?	No ☐	Yes ☐
Are you taking any anticoagulant medication? This is medication that prevents your blood clotting. Examples include warfarin, apixaban, rivaroxaban, dabigatran and edoxaban.	No ☐	Yes ☐
Do you have a weakened immune system caused by an illness, disease or medication?	No ☐	Yes ☐

Consent to vaccination

Have you read the written information provided?	Yes ☐	No ☐
Do you agree to be monitored for at least 15 minutes following vaccination?	Yes ☐	No ☐
Based on the information you have read do you consent to receive the Covid-19 vaccine following assessment by a vaccinator?	Yes ☐	No ☐

Signature:		**Date:**	