Patient Consent Form COVID-19 Vaccine

Name (BLOCK CAPITALS)	
Date of Birth:	
PPS Number:	
Home Address:	
E-mail address: (BLOCK CAPITALS)	

	YES	NO
Have you received explanatory information about COVID-19 vaccination?		
Do you understand the information and can you make an informed decision to consent?		
Do you understand the full COVID-19 vaccine is given in 2 separate doses, 28 days apart?		
Have you ever had a serious allergic reaction requiring medical intervention?		
Have you been diagnosed with COVID-19 in the last 4 weeks?		
Have you had any other vaccine within the last 14 days?		
Do you have a bleeding disorder / are you on anti-coagulant therapy?		
Do you consent to receiving COVID-19 vaccine?		

SIGNATURE: _____ DATE: _____