Covid 19 vaccine consent form

Covid 19 is a viral infection that affects your lungs and airway. In many cases the symptoms are mild but in some people especially those over 65 and with certain medical conditions it can cause hospitalisation and even death.

The Pfizer / BioNTech + Moderna vaccines are mRNA vaccines. They teach your body to make a protein that will trigger an immune response, without using the live protein that causes Covid 19. This helps your body make antibodies that will fight the virus if it enters your body in the future.

The vaccine is given by an injection in your upper arm. (**We would advise you to wear short sleeves to make administration easier).**

What are the side effects of the vaccine?

Most side effects are mild to moderate and short-term, not everyone gets them.

More than 1 in 10 people may experience any of the following:

- Tenderness, redness or swelling at the injection site
- Headache, Tiredness, Fever or nausea.
- Muscle or joint pain

More than 1 in 1000 people may develop itchiness where the vaccine is given swelling of lymph glands or sleepiness. Bell's palsy is rare and seen in more than 1 in 10,000 people.

Serious side effects to vaccines, like a severe allergic reaction are extremely rare, seen in less than 1 in 100,000 people. Your vaccinator is trained to treat very rare serious allergic reactions.

You should not get the vaccine if:

1. You have had severe allergic reaction to any of the ingredients in the vaccine. Read the patient information leaflet to see these ingredients, it is available through the HSE website.

2. You have had a severe allergic reaction (anaphylaxsis) to a previous dose of a vaccination or other injectable treatment.

3. You have been diagnosed with Covid 19 within 4 weeks of your vaccination date.

I have informed myself by reading the Covid 19 patient information leaflets on the HSE website.   hse.ie

I confirm that I have read and understand the above information and consent to receive the vaccine.

Patient name …………………………………………………………….……

Patient signature ……………………………………………………………	Date ……………………………………………………..