

**COVID-19 Vaccination Consent Form**

**Care Homes**

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| --- | --- |
| Name of Patient: | Date of Birth: |
| NHS Number: | Gender: |
| GP Practice: | Care Home: |
| **PRE-SCREENING QUESTIONS** | | |
| Have you been provided with information about the vaccine? |  |
| Do you have any history of reaction to a COVID vaccine? |  |
| Do you have a history of allergies? |  |
| The VidPrevtyn Beta vaccine contains an ingredient derived from a fish oil. Do you have any religious, ethical or medical reasons why you cannot have this vaccine? |  |
| **CONSENT FOR PATIENTS WITH CAPACITY** | |
| I want to receive the full course of vaccination | I do not want to receive the full course of vaccination |
| Name | Name |
| Signature | Signature |
| Date | Date |
| **RELATIVE AGREEMENT FOR COVID-19 VACCINATION (PLEASE COMPLETE ONE BOX ONLY)** | |
| I would agree with a decision that it is in the best interests of the resident named above to receive the full course of COVID-19 vaccination | I would not agree with a decision that it is in the best interests of the resident named above to receive the full course of COVID-19 vaccination |
| Name | Name |
| Signature | Signature |
| Date | Date |
| If, after discussion, you decide that you do not agree that it is the best interests of the above-named resident to have the vaccine, it would be helpful if you would give the reasons for this below. | |
| **WHERE PATIENT HAS NO CAPACITY TO CONSENT** | |
| Main Carer or Meaningful Person: | Details of Other Professionals Consulted: |
| Name of Decision Maker/Assessor: | Designation: |
| Date / Time Assessment: |  |

***Every adult should be assumed to have the capacity to make an informed decision; unless it is proved that they lack capacity. An assumption about someone’s capacity cannot be made on the basis of a person’s age, appearance, condition, or aspect of their behaviour.***

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| --- | --- | --- | --- | --- | --- |
| 1. **Decision:** Whether this patient wishes to have a COVID Vaccination | | | | | |
| 1. **Assessment of Capacity:** Is there an impairment of or disturbance in the functioning of the person’s mind or brain?*(For example, symptoms of alcohol or drug use, delirium, concussion, head injury, conditions associated with mental illness, dementia, significant learning disability, brain damage, confusion, drowsiness, or loss of consciousness due to a physical or medical condition)*   **NO** (If you have answered NO, the person is considered not to lack Mental Capacity within the meaning of the Mental Capacity Act. You do not need to proceed any further with this assessment.  **YES** (provide evidence): | | | | | |
| 1. **Please complete the following questions in order to form an opinion as to whether the impairment is sufficient to suggest that the person lacks the capacity to make the particular decision at this moment in time.** | | | | | |
| Do you consider the person is **able to understand the information relevant to the decision** and that this information has been provided in a way that the person is most likely able to understand? | **YES/NO** | | Do you consider the person is **able to use or weigh that information** as part of the process of making the decision? | **YES/NO** |
| Do you consider the person is **able to retain the information for long enough** to be able to make the decision? | **YES/NO** | | Do you consider the person is able to communicate their decision? | **YES/NO** |
| **ATTORNEY FOR HEALTH AND WELFARE CONSENT FOR COVID-19 VACCINATION** | | | | | |
| I would agree with a decision that it is in the best interests of the resident named above to receive the full course of COVID-19 vaccination | | I do not want to give consent for the resident named above receive the full course of COVID-19 vaccination | | |
| Name | | Name | | |
| Signature | | Signature | | |
| Date | | Date | | |