

The Surgery, Mayor's Walk, Waterford.

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Name: PPSN (mandatory):.....

Date of Birth

Part 1: Please answer all of the following questions:

Question	Answer Yes / No as appropriate	Action based on response given to question
Have you had Anaphylaxis (serious systemic allergic reaction requiring medical intervention) following a previous dose of the vaccine or any of its constituents, including polyethylene glycol?		If yes , you are not eligible for vaccination at this time
Have you been diagnosed with COVID-19 within the last 4 weeks?		If yes , you will not be eligible for vaccination until 4 weeks after your COVID symptoms finished
Have you had another vaccine within the last 14 days?		If yes , you will not be eligible for vaccine until 14 days after your last vaccine
Do you have a bleeding disorder or are on anticoagulation therapy?		No action on either yes or no, knowledge transfer to vaccinator

Part 2: Please access

www.hse.ie/screening-and-vaccinations/covid-19-vaccine

and www.hse.ie/Coronavirus & www.hpsc.ie for information

YES	
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I have read and understand the vaccine information, including known side effects

I understand that I am giving consent for the administration of two doses of COVID-19 vaccine at the appropriate interval

Signed Date.....

Name(Print)