**Vaccination Consent Form**

**Email to care home service mailbox: cmicb-wi.hwwpcncarehomesupport@nhs.net**

|  |  |
| --- | --- |
| **Care Home Name:** |  |
| **Residents Full Name:** |  |
| **Date of Birth:** |  |
| **LPA for Health & Welfare Details:** |  |
| **Known allergies:** |  |
| **Anticoagulant medication:** |  |

**Please select all that apply:**

|  |  |  |
| --- | --- | --- |
| Resident has the capacity to make decisions regarding their health | Y | N |
| Resident has fluctuating capacity but understands their decision to consent or decline the **COVID-19 vaccination** | Y | N |
| Resident has fluctuating capacity but understands their decision to consent or decline the **seasonal influenza vaccination** | Y | N |
| Resident has an activated LPA for Health in place | Y | N |
| Resident lacks capacity and does not have an LPA in place – therefore a best-interest decision is required for this patient (this will be done by the vaccinator on the day) | Y | N |

|  |  |
| --- | --- |
| Signature of consenting resident |  |
| Date |  |

**For patients requiring consent on their behalf please complete the below information**

While the above-named patient is a resident at the above-named care home, I understand that Healthier West Wirral PCN will offer appropriate vaccinations as part of their ongoing care and treatment. Vaccines will be offered in line with ICB regulations and the brand type depending on availability. Vaccinations will continue to be administered when appropriate unless I, the residents lasting power of attorney for Health Care Decisions or another legal advocate for the patient informs you otherwise. I also understand vaccines will not be administered if it is medically inappropriate and this will be decided at the time of administration. I hereby consent to the administration of vaccinations for the above-named patient.

|  |  |  |
| --- | --- | --- |
| Name of staff member filling in form |  | |
| Name of person giving consent i.e. LPA/ next of kin / staff if no NOK |  | |
| Relationship to patient |  | |
| Do you consent to the administration of the ongoing **Covid-19 vaccination** | **Y** | **N** |
| Do you consent to the administration of the ongoing **seasonal influenza vaccination** | **Y** | **N** |
| Was consent received: in person / via telephone / via email to care home | | |
| Date |  | |

|  |  |
| --- | --- |
| Does this patient have any information or communication support needs relating to a disability, impairment, or sensory loss? |  |
| If yes, please give details as to how we can help to support this patients’ needs appropriately |  |