Consent Form for Adults

This form should be used to record the administration of MVA-BN vaccine Version 6.0 12 September 2022

Privacy Statement: HSE staff are aware of their obligation under the Data Protection Acts, 1988-2018 (including GDPR). The information provided will be included in an Immunisation Database. The HSE will use this information to validate clients, monitor vaccination programmes and provide health care.

Section 1: Personal Details

Complete this part for the person getting vaccinated (PLEASE USE BLOCK CAPITALS)

First name: Surname (Family Name):

Personal Public Service Number (PPSN):

Date of Birth: D D / M M / Y Y Y Y What sex were you assigned at birth: (please circle) Male Female

What is your gender identity: (please circle) Male (including trans male) Female (including trans female) Non-binary

Address

County: Eircode:

Mobile Phone Number: Email Address:

GP Name and Address:

Healthcare workers only - What hospital or service do you work in?

Please answer the following questions	**(Circle your answer)**	
Have you ever received MVA-BN or another smallpox vaccine?	**Yes**	**No**
If yes, what was the name of the vaccine?		
What date did you receive it? D D / M M / Y Y Y Y		
Have you had any allergies to any vaccines in the past?	**Yes**	**No**
Have you had any allergies to eggs or egg products (including chicken or feathers) in the past?	**Yes**	**No**
Do you have any serious allergies?	**Yes**	**No**
If yes, please specify		
Do you currently have a raised temperature or feel unwell?	**Yes**	**No**
Do you have atopic dermatitis?	**Yes**	**No**
Do you have a history of keloid scar formation?	**Yes**	**No**
Do you have a condition or are you receiving treatment that weakens your immune system?	**Yes**	**No**
Are you pregnant?	**Yes**	**No**
Are you breastfeeding?	**Yes**	**No**
Do you plan to receive a COVID-19 vaccine in the next 4 weeks?	**Yes**	**No**

Section 2: Consent

Please tick the box for each statement and sign to give consent to be vaccinated

I have been made aware of possible risks, benefits and side effects to these vaccines. ☐

I consent to receiving a course of MVA-BN (1 or 2 doses 28 days apart) as determined by a suitable healthcare professional ☐

Signature: Date: D D / M M / Y Y Y Y

FOR OFFICE USE ONLY

Is this person receiving? (circle answer) **Pre Exposure Vaccination** **Post Exposure Vaccination**

Dose No.	Date Given (DD/MM/YYYY)	Vaccine Name & Manufacturer	Batch Number	Expiry Date Month/Year	Use by date	Injection Site	Injection Route
1							
2							

Prescriber Signature: HSE Clinic / Hospital Name, Address, or Stamp

PIN/MCRN:

Vaccinator Signature:

PIN/MCRN: