COVID-19 (V02 - 13042021)

MINISTRY OF HEALTH AND SOCIAL SERVICES

NAMIBIA COVID-19 VACCINE CONSENT FORM

Name of Health Facility Vaccination site is attached to:		Name of site Vaccination is administered:		
District:	Region:	☐ Outreach/Mobile:		
Recipient First & Last name:		Sex: ☐ Male ☐ Female		DOB: ____/____/________
Recipient's Physical Address:		Identity Nr / Passport Nr.:		Nationality:
Recipient's Contact details:		Namibian Medical Aid: ☐ Yes ☐ No		Specify, Medical Aid Name: Medical Aid No:
Next of Kin: First and Last Name:		Next of Kin Contact details:		

Health Workers must review sections below with the client o obtain consent

EMERGENCY USE AUTHORIZATION

The Ministry of Health and Social Services / Namibia Medicine Regulatory Council (NMRC) has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic.

CONSENT

1. I have been provided with and have read/have been explained in my own language, the explanation regarding the nature of and implication of the vaccine, the fact sheet about the said vaccine which has been provided to me.
2. I understand that if this vaccine requires two doses, the two doses of this vaccine shall be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction / I have ensured that the person named above for whom I am authorised to provide consent for was also given a chance to ask questions (in case of a guardian). I understand the benefits and known side effects of the vaccine.
3. I give permission for the vaccine to be administered to me/the person named above for whom I am authorised to make this request and provide consent (In case of guardian).
4. I have been informed that after administration of the vaccine, I will be kept under observation for a period for up to 30 minutes.
5. I authorize the release of all information needed, including but not limited to medical records as may be required for other public health purposes.

WAIVER

1. I acknowledge that vaccination like other medicines may have some known side effects. Adverse event following immunisation that may occur have explained to me.
2. I voluntarily seek and accept vaccination for COVID-19.
3. I have read/heard and fully understand the contents of this form and I execute it voluntarily.
4. I undertake to attend any vaccination centre on the date scheduled for the second dose (For vaccines requiring two doses).

Recipient/Guardian (Signature):______________________________ Print Full Name:______________________________

Relationship to patient, if other than recipient:______________________________

Signed at ______________________________ Date: ____/____/________

Area Below to be Completed by Vaccinator Which vaccine is the patient receiving today?

Vaccine Name	Administration			EUA Fact Sheet Date	Manu / Lot Nr
Pfizer/ BioNTech	☐ First Dose	☐ Second Dose	☐ Third Dose		
Moderna	☐ First Dose	☐ Second Dose	☐ Third Dose		
Astra-Zeneca	☐ First Dose	☐ Second Dose	☐ Third Dose		
Janssen	☐ Single Dose				
Sinovac	☐ First / Single Dose	☐ Second Dose	☐ Third Dose		
SinoPharm	☐ First / Single Dose	☐ Second Dose	☐ Third Dose		
Other:	☐ First / Single Dose	☐ Second Dose	☐ Third Dose		

Administration Site ☐ Left Deltoid ☐ Right Deltoid ☐ Left Thigh ☐ Right Thigh

Dosage ☐ 0.5 ml ☐ 0.3 ml

I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Name and Surname: ______________________________

Vaccinator Signature: ______________________________

MINISTRY OF HEALTH AND SOCIAL SERVICES

Vaccination Screening Form

Name of Health Facility Vaccination site is attached to:	Name of site Vaccination is administered:	
Region: ______________	District: ______________	☐ Outreach / Mobile
Recipient First & Last name:	Sex ☐ Male ☐ Female	DOB: ___/___/____ Age: ☐ Estimated Age
Recipient's Physical Address	Identity Nr / Passport Nr.	Nationality
Recipient's Contact details	Namibian Medical Aid ☐ Yes ☐ No	Medical Aid Name; Medical Aid No;
Next of Kin first and Last Name	Next of Kin Contact details	

OUTCOME OF SCREENING	
VACCINATE ☐	DO NOT VACCINATE☐

Does the recipient fall under the vaccination eligibility stage, currently being vaccinated?	☐	Yes	☐	No

Vital Signs / Clinical Observations

____

____

____

____

____

____

1	Have you received a previous dose of COVID-19 vaccine? If no continue to question no 2.	☐ Yes ☐ No ☐ Unknown
1.1	Is this your second dose? *Verify using vaccinate certificate.*	☐ Yes ☐ No ☐ Unknown
1.2	If this is your second dose, when was the date of your first dose? *Verify using vaccinate certificate.*	___/___/_____ ☐ Unknown
1.3	If this is your second dose, which vaccine did you receive (AstraZeneca, SinoPharm, etc)? *Verify using vaccinate certificate.If available insert vaccine cert nr.*	☐ Unknown
2	Are you feeling sick today? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	☐ Yes ☐ No ☐ Unknown
3	In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate at home due to COVID-19 infection?	☐ Yes ☐ No ☐ Unknown
4	In the last 10 days, have been told by a healthcare provider or health department to quarantine at home due to COVID-19 exposure or travel?	☐ Yes ☐ No ☐ Unknown

5	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?*	☐ Yes ☐ No ☐ Unknown
6	Have you ever had an immediate allergic reaction, such as hives, facial swelling, difficulty breathing or anaphylaxis, to any vaccine or shot or to any component of the COVID-19 vaccine, such as polyethylene glycol (PEG) or polysorbate? or a history of anaphylaxis due to any cause?	☐ Yes ☐ No ☐ Unknown
7	Have you had any vaccines in the past 14 days (2 weeks) including flu shot?	☐ Yes ☐ No ☐ Unknown
	If yes, how long ago was your most recent vaccine? Date; ___/___/_____	☐ Yes ☐ No ☐ Unknown
8	Are you pregnant?	☐ Yes ☐ No ☐ Unknown
9	Are you currently breastfeeding?	☐ Yes ☐ No ☐ Unknown
10	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐ Yes ☐ No ☐ Unknown
11	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	☐ Yes ☐ No ☐ Unknown
12	Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes ☐ No ☐ Unknown

INFORMATION FOR HEALTH CARE PROFESSIONALS ABOUT VACCINATION ELIGIBILITY

1. Are you pregnant?

   IF YES: Please ask the patient whether they discussed vaccination with a medical provider. Patients who are pregnant may choose to be vaccinated if they feel they are at risk after providing evidence of approval from a medical provider.

2. Are you currently breastfeeding?

   IF YES: Please ask the patient whether they discussed vaccination with a medical provider. Patients who are lactating may choose to be vaccinated if they feel they are at risk after providing evidence of approval from a medical provider.

3. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to a vaccine or injectable therapy, or a history of anaphylaxis due to any cause?

   IF YES: Please ask the patient evidence of approval from a medical provider. If they have, allow vaccination to proceed. Vaccine providers should observe patients after vaccination to monitor for the occurrence of immediate adverse reactions:
   - **Persons with a history of anaphylaxis: 30 minutes**
   - **All other persons: 15 minutes**

4. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of thevaccine?

   IF YES: Do Not Vaccinate

5. Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next14 days?

   IF YES: Do Not Vaccinate

6. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?

   IF YES: Have patient discuss existing symptoms with a medical provider.

7. Do you have a bleeding disorder or are you taking a blood thinner?

   IF YES: Have patient been approved to receive vaccination by a medical provider. The US-CDC's *Advisory Committee on Immunization Practices* (*ACIP*) recommends the following technique for intramuscular vaccination in patients with bleeding disorders or taking blood thinners: a fine-gauge needle (23-gauge or smaller caliber) should be used for the vaccination, followed by firm pressure on the site, without rubbing, for at least 2 minutes.

8. Have you tested positive for COVID-19 in the last 10 days?

   IF YES: Do Not Vaccinate

9. Are you currently in quarantine for COVID-19 exposure?

   IF YES: Do Not Vaccinate

10. If this is your second dose, when was the date of your first dose?

    Do Not Vaccinate if less than 3, 4 and 12 weeks for Moderna, Pfizer and Oxford-AstraZeneca vaccines respectively

11. If this is your second dose, which vaccine did you receive (AstraZeneca/Oxford, SinoPharm, Serum Institute of India etc)?

    Ensure that the second dose is from the same vaccine type as the first dose. If different: Do Not Vaccinate.

Ministry of Health and Social Service Republic of Namibia
Vaccine eligibility flow chart