

PLEASE BRING A SIGNED COPY OF THIS CONSENT FORM.

Student's COVID-19 Vaccination Questionnaire: Complete the form for each vaccine.

First Dose / Second Dose (12 years – 14 years) – CorBEvax Vaccine

First Dose / Second Dose (15 years – 18 years) – Covaxin Vaccine

Student's First Name: _____ Surname: _____

Class: _____ Section: _____ Date of Birth: _____

Residence Address: _____

Phone/Mobile: _____

Email: _____

Aadhaar Number: _____

Co-Win Registration Number: _____

As your vaccinator does not always have access to your medical details, please answer the following questions to ensure it is safe for you to have your vaccination.

Questions:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Are you well today? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had been diagnosed with COVID-19 in the last 28 days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had any other vaccinations in the last 7 days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had a severe allergic reaction or anaphylaxis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you suffer from a bleeding disorder or take any type of anticoagulant (blood thinner)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you suffer from any condition, or take any medication or treatment, that may affect your immune system (eg. cancer, cancer treatments, high dose steroids, etc) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you taking any regular medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had a COVID-19 vaccination in the last 28 days? | <input type="checkbox"/> | <input type="checkbox"/> |

I declare that the above declarations are true.

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Full Name: _____

Parent/Guardian's Mobile: _____

PARENT / GUARDIAN CONSENT FORM FOR MINOR TO RECEIVE COVID-19 VACCINE

I,, being the parent / guardian / authorised representative authorized to consent for Covid-19 vaccination for the minor child listed below, hereby give my informed consent and permit authorized medical team of Bidhannagar Municipal Corporation (BMC) to administer the COVID – 19 vaccine to my child.

I understand that following the delivery of the vaccine, BMC will observe my child for a 30-minute period to monitor for an adverse reaction if the minor is unaccompanied. In case of a reaction, the attendant (parent /guardians/authorised representative) shall be responsible to arrange medical care of the minor.

I fully understand that this is a voluntary service as part of its community service initiative and I will not hold the school responsible for any eventuality of any adverse event following vaccination.

I further acknowledge that this consent may be verified either in person or verbally over telephone before the vaccine is administered if there are queries.

I understand that my child will receive a COVID -19 vaccine approved under India's National COVID-19 Vaccination Program.

I understand the benefits and risks of vaccination and I give permission for my child to be vaccinated.

Details:

- ❖ Name of Minor (student) receiving vaccine:
- ❖ Name of School:
- ❖ Name of Parent / Guardian / Authorised Representative:
- ❖ Contact No. of Parent / Guardian / Authorised Representative:

Signature of Parent / Guardian / Authorised Representative:

Date: