MINISTRY OF HEALTH AND WELLNESS

REGISTRATION AND CONSENT FOR COVID-19 VACCINATION

PART I – REGISTRATION FORM

Recipient name		National Identity Card no./Passport no.	
Date of birth	Gender	Married/Unmarried	
Age		Details pertaining to parent/guardian	
Address		Details pertaining to next of kin	
Occupation		Email address	
Parent/guardian (if applicable)		Phone No.	Preferred language
Name of COVID-19 Vaccination Centre NOUVELLE CLINIQUE DU BON PASTEURLTEE			

Emergency Use Authorisation

The Ministry of Health and Wellness has made the COVID-19 vaccine available following regulatory approval of its use in the United States, United Kingdom, India and other countries as circumstances justify its use in an emergency such as the COVID-19 pandemic. This vaccine has not completed the same type of review and process in those countries as would have been the case in normal circumstances and the Ministry of Health and Wellness is making the vaccine available due to existence of a public health emergency and on the basis of the totality of scientific evidence available for the time being, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

PART II – CONSENT FORM

1. I have been provided with and have read/have been explained in my own language*, the explanations regarding the nature of and implications of the vaccine, the fact sheet about the said vaccine which has been provided to me. I understand that if this vaccine requires 2 doses, the 2 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/have ensured that the person named above for whom I am authorised to provide consent was also given a chance to ask questions*. I understand the benefits and risks of the vaccine.

2. I request that the vaccine be administered to me/the person named above for whom I am authorised to make this request and provide consent*. I understand there will be no cost to me for this vaccine. I have been informed that after administration of the vaccine, I will be kept under observation for a period of at least 30 minutes. I authorise release of all information needed, including but not limited to medical records, such information provided by me for the purposes of this form as may be required for other public health purposes, including reporting to any public health institution.

Waiver, Release and Hold Harmless Agreement

3. I, together with my parent or guardian, if I am under the age of 18 or under a legal disability, represent, covenant and agree, on behalf of myself and my heirs, assigns, and any other person claiming by, under or through me, as follows –

(a) I acknowledge that as a result of the vaccination certain risks are involved and that any adverse event following immunisation which might include injuries and death could occur to me. I accept and voluntarily incur and assume all risks of any adverse event following immunisation, including injuries and death that arise during or result from the administration of the vaccine;

(b) without limiting my assumption of the general risks described above, I specifically understand and acknowledge the following with regard to the novel coronavirus, COVID-19 –

(i) COVID-19 has been declared a worldwide pandemic by the World Health Organization;

(ii) COVID-19 is an infectious virus that is extremely contagious and spreads easily through person-to-person contact and/or by contact with contaminated surfaces and objects, and even possibly in the air;

(ii) those infected with COVID-19 may show no symptoms and still spread the disease, including through interpersonal communications and sharing spaces with others;

(iv) COVID-19 can cause serious and potentially life threatening illness and even death;

(v) COVID-19 has recently shown signs of mutation in several countries like the United Kingdom, Brazil, South Africa and Japan.

4. Notwithstanding the foregoing, I hereby choose to accept, and freely and voluntarily assume, the risks set out in this Form.

5. I waive all claims against the State of Mauritius, the Global Health Partnership also known as GAVI Alliance, donor States or organisations, manufacturers of the vaccine and their agents or preposés, any vaccinator, any hospital or private health institution authorised by the Minister, to administer the vaccine for any adverse event following immunization, including injuries and death, whether known or unknown, foreseen or unforeseen, which arise from/during or as a result of the vaccine, regardless of whether or not caused, in whole or part, by the negligence or other fault on their part, I release and forever discharge them from all claims.

6. I agree to indemnify and hold the above parties harmless from and against any and all losses, liabilities, damages, costs or expenses, including but not limited to reasonable attorneys' fees and other litigation costs and expenses incurred by any of these parties as a result of any claims or suits that I (or anyone claiming by, under or through me) may bring against any of them to recover any losses, liabilities, costs, damages, or expenses that arise during or result from the vaccine.

7. I have carefully read and reviewed this Waiver, Release and Hold Harmless Agreement/The above has been carefully explained to me in my own language* and given assistance in responding to questions set out in the fact sheet.

8. I have read and fully understand the contents of this Form/have been explained in my own language* and fully understand the contents of this Form and I execute it voluntarily.

9. I undertake to –

(a) attend the same vaccination centre on the date scheduled for the second dose as specified in this Form and in such COVID-19 Vaccination Record Card provided to me;

(b) attend the same vaccination centre where the vaccine was administered in case any adverse event following immunisation; and

(c) bring and produce the COVID-19 Vaccination Record Card provided to me.

.....	.....	.....
Signature of recipient/ parent/guardian	Name	Relationship to patient, if other than recipient
.....		.....
Date		Time

PROCEED TO VACCINE ADMINISTRATION STATION

First dose vaccine		
Date	Brand of Vaccine**	Other ☐ (please specify)
Dosage given	AstraZeneca ☐	
Time of Vaccination	Pfizer ☐	
	Batch no.	
	Date of expiry	

I have reviewed the contents of this Registration and Consent Form with patient/parent of patient/guardian of patient*.

I confirm that the patient/parent of patient/guardian of patient* was given an opportunity to ask questions about the vaccine, and I have, to the best of my ability, answered all the questions asked by them.

I confirm that recipient of the vaccine is an eligible person.

..... Name of recipient/parent/ guardian	..... Signature of recipient/parent/ guardian
..... Name of Doctor who explained the above	..... Signature of Doctor who explained the above
..... Name of Vaccinator	..... Signature of Vaccinator
..... Name of witness	..... Signature of witness

..... Date

Observation Period at Vaccination Centre (To be filled by health care personnel)		
Observation period at Vaccination Centre	Time in	Time out
Adverse Event Following Immunisation noted		
Expected date of second dose		

Second dose vaccine		
Date	Brand of Vaccine** AstraZeneca ☐ Pfizer ☐	Other ☐ (please specify)
Dosage given		
Time of Vaccination	Batch no.	
	Date of expiry	

I have reviewed the contents of this Registration and Consent Form with patient/parent of patient/guardian of patient*.

I confirm that the patient/parent of patient/guardian of patient* was given an opportunity to ask questions about the vaccine, and I have, to the best of my ability, answered all the questions asked by them.

I confirm that recipient of the vaccine is an eligible person.

..... Name of recipient/parent guardian	..... Signature of recipient/parent guardian
..... Name of Doctor who explained the above	..... Signature of Doctor who explained the above
..... Name of Vaccinator	..... Signature of Vaccinator
..... Name of witness	..... Signature of witness

..... Date

Observation Period at Vaccination Centre (To be filled by health care personel)		
Observation period at Vaccination Centre	Time in	Time out
Adverse Event Following Immunisation noted		

Notes

*Delete as appropriate.

**Tick as appropriate.