Australian Government

COVID-19 VACCINATION

Consent form for COVID-19 vaccination (Comirnaty Pfizer vaccine)

On the day you receive your vaccine

Before you get vaccinated, tell the person giving you the vaccination if you:

- Have had an allergic reaction, particularly anaphylaxis (a severe allergic reaction) to a previous dose of a COVID-19 vaccine, to an ingredient of a COVID-19 vaccine, or to other vaccines or medications
- Are immunocompromised. This means that you have a weakened immune system that may make it harder for you to fight infections and other diseases. You can still have a COVID-19 vaccine, but may wish to consider the best timing of vaccination depending on your underlying condition and/or treatment

YES	NO	
☐	☐	Have you been sick with a cough, fever or sore throat or are feeling sick in any other way?
☐	☐	Have you been in any COVID hotspots in the last 14 days?
☐	☐	Have you had a covid test in the last 14 days?
☐	☐	Is anyone in your household isolating or had a covid test in the last 14 days?
☐	☐	Have you received any other vaccine in the last 7 days?
☐	☐	Have you had a first dose of AstraZeneca COVID vaccine before?
☐	☐	Are you 60 years or older?
☐	☐	Have you had an allergic reaction to a previous dose of a COVID-19 vaccine?
☐	☐	Have you had any anaphylaxis to another vaccine or medication?
☐	☐	Do you have a mast cell disorder?
☐	☐	Do you have a bleeding disorder?
☐	☐	Do you take any medicine to thin your blood (an anticoagulant therapy)?
☐	☐	Do you have a weakened immune system (immunocompromised?)
☐	☐	Are your pregnant?
☐	☐	Have you had a COVID vaccination before?

Patients Name: _____ Date of Birth: _____

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Consent to receive COVID-19 vaccine

- ☐ I confirm I have received and understood information provided to me on COVID-19 vaccination
- ☐ I confirm that none of the conditions above apply, or I have discussed these and/or any other special circumstances with my regular health care provider and/or vaccination service provider
- ☐ I agree to receive a course of COVID-19 vaccine (two doses of the same vaccine)

Patients Name: _____ Date of Birth: _____

Patients Signature_____ Date: _____

Medicare Number: _____

Contact Number: _____

Next of kin (in case of emergency)

Name: _____

Phone contact number: _____