

Consent form for COVID-19 vaccination

Before completing this form make sure you have read the information sheet on the vaccine you will be receiving, either COVID-19 Vaccine AstraZeneca or Comirnaty (Pfizer).

About COVID-19 vaccination

People who have a COVID-19 vaccination have a much lower chance of getting sick from the disease called COVID-19.

There are two brands of vaccine in use in Australia. Both are effective and safe. For adults aged under 50 either brand may be used, however Comirnaty (Pfizer) vaccine is preferred over AstraZeneca COVID-19 vaccine.

You need to have two doses of the same brand of vaccine. The person giving you your vaccination will tell you when you need to have the second vaccination.

Medical experts have studied COVID-19 vaccines to make sure they are safe. Most side effects are mild. They may start on the day of vaccination and last for around 1-2 days. As with any vaccine or medicine, there may be rare and/or unknown side effects.

A very rare side effect of blood clotting has been reported in the 4-20 days after the first dose of AstraZeneca COVID-19 vaccine. This is not seen after the second dose of AstraZeneca COVID-19 vaccine or after any dose of Comirnaty (Pfizer) vaccine. For further information on the risk of this rare condition refer to the '[Information on COVID-19 Vaccine AstraZeneca](#)' fact sheet.

You can also tell your healthcare provider if you have any side effects like a sore arm, headache, fever or any other side effect you are worried about. You may be contacted by SMS within the week after receiving the vaccine to see how you are feeling after vaccination.

Some people may still get COVID-19 after vaccination. So you must still follow public health precautions as required in your state or territory to stop the spread of COVID-19 including:

- keep your distance – stay at least 1.5 metres away from other people
- washing your hands often with soap and water, or use hand sanitiser
- wear a mask,
- stay home if you are unwell with cold or flu-like symptoms and arrange to get a COVID-19 test.

Vaccination providers record all vaccinations on the Australian Immunisation Register, as required by Australian law. You can view your vaccination record online through your:

- Medicare account
- MyGov account
- MyHealthRecord account

How is the information you provide at your appointment used

For information on how your personal details are collected, stored and used visit <https://www.health.gov.au/covid19-vaccines>

On the day you receive your vaccine

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

- Have any allergies, 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 medication.
- If you are immunocompromised. This means that you have a weakened immune system that may make it harder for you to fight infections and other diseases.
- If you have a past history of cerebral venous sinus thrombosis (a type of brain clot) or heparin induced thrombocytopenia (a rare reaction to heparin treatment)

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Patient Information		Dose 1 or 2 (office use)																																																
Name:	Date of birth:																																																	
Address:																																																		
Phone number:	Medicare Card Number: Ref number																																																	
email:	Gender: Male / Female / Other																																																	
Next of kin (in case of emergency) Name:		Phone:																																																
<p>Are you Aboriginal and / or Torres Strait Islander?</p> <p><input type="checkbox"/> Aboriginal</p> <p><input type="checkbox"/> Torres Strait Islander</p> <p><input type="checkbox"/> Aboriginal and Torres Strait Islander</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Prefer not to answer</p>																																																		
<p>Questions: Please answer the following questions: Please talk to your doctor if you have any questions or concerns before getting your COVID-19 vaccination.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%; padding: 5px;">Yes</th> <th style="width: 10%; padding: 5px;">No</th> <th style="padding: 5px;"></th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Do you have any serious allergies, particularly anaphylaxis, to anything?</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Have you had an allergy reaction after being vaccinated before?</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Do you have a mast cell disorder?</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Have you had COVID-19 before?</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Do you have a bleeding disorder?</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Do you take any medicine to thin your blood (an anticoagulant therapy)?</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Do you have a weakened immune system (immunocompromised)?</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Are you pregnant?</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Have you been sick with a cough, sore throat, fever or are feeling sick in another way?</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Have you had a COVID-19 vaccination before?</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Have you received any other vaccination in the last 14 days?</td> </tr> <tr> <td colspan="3" style="padding: 5px;"><i>Relevant for AstraZeneca COVID-19 vaccine only*:</i></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Have you had cerebral venous sinus thrombosis in the past?</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Have you had heparin-induced thrombocytopenia in the past?</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Are you under 50 years of age?</td> </tr> </tbody> </table>			Yes	No				Do you have any serious allergies, particularly anaphylaxis, to anything?			Have you had an allergy reaction after being vaccinated before?			Do you have a mast cell disorder?			Have you had COVID-19 before?			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 you pregnant?			Have you been sick with a cough, sore throat, fever or are feeling sick in another way?			Have you had a COVID-19 vaccination before?			Have you received any other vaccination in the last 14 days?	<i>Relevant for AstraZeneca COVID-19 vaccine only*:</i>					Have you had cerebral venous sinus thrombosis in the past?			Have you had heparin-induced thrombocytopenia in the past?			Are you under 50 years of age?
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<p>*AstraZeneca COVID-19 vaccine is suitable for people in these three categories if they have assessed their benefits and risks. For more information refer to the: Information on COVID-19 Vaccine AstraZeneca fact sheet.</p>																																																		

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 (two doses of the same vaccine)

Patient's name:	
Patient's signature:	
Date	

- I am the patient's legal guardian or legal substitute decision-maker, and agree to COVID-19 vaccination of the patient named above.

Guardian/substitute decision-maker's name:	
Guardian/substitute decision maker's signature:	
Date	

For Provider use:

Dose 1:	Date vaccine administered	
	Time received	
	COVID-19 vaccine brand administered	
	Batch number	
	Serial number	
	Site of vaccine injection	
	Name of vaccination service provider	

Dose 2:	Date vaccine administered	
	Time received	
	COVID-19 vaccine brand administered	
	Batch number	
	Serial number	
	Site of vaccine injection	
	Name of vaccination service provider	