

COVID-19 VACCINATION CONSENT

How the information you provide is 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 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

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had an allergic reaction to a previous dose of a COVID-19 vaccine? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had anaphylaxis to another vaccine or medication? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a mast cell disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had COVID-19 before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a bleeding disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take any medicine to thin your blood (an anticoagulant therapy)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a weakened immune system (immunocompromised)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?* |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been sick with a cough, sore throat, fever or are feeling sick in another way? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a COVID-19 vaccination before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you received any other vaccination in the last 7 days? |

Relevant for AstraZeneca COVID-19 vaccine only:

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had cerebral venous sinus thrombosis? * |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heparin-induced thrombocytopenia? * |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had blood clots in the abdominal veins? * |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had antiphospholipid syndrome associated with blood clots? * |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you under 60 years of age? * |

* If Comirnaty is not available, AstraZeneca COVID-19 vaccine can be considered for people in these groups, if the benefits of vaccination outweigh the risk. For more information refer to the: '[Patient information sheet on thrombosis with thrombocytopenia syndrome \(TTS\)](#)'

Patient information

Name:	
Medicare number:	
Individual Health Identifier (IHI) if applicable:	
Date of birth:	
Address:	
Phone contact number:	
e-mail:	
Gender:	

Language spoken at home:	
Country of birth:	

Are you Aboriginal and/or Torres Strait Islander?

- Yes, Aboriginal only
- Yes, Torres Strait Islander only
- Yes Aboriginal and Torres Strait Islander
- No
- Prefer not to answer

Next of kin (in case of emergency):	
Name:	
Phone contact number:	

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)

Patient's name:	
Patient's signature:	
Date:	

- I am the patient's guardian or 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:	