Consent form for COVID-19 vaccination

Name:												
Medicare number:												

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 one or two days. As with any vaccine or medicine, there may be rare or unknown side effects.

Myocarditis and pericarditis (heart inflammation) have been reported following Pfizer . Most cases have been mild and people have recovered quickly.

By law, the person giving your vaccination must record it on the Australian Immunisation Register. You can view your vaccination record online through your:

- Medicare account
- MyGov account
- My Health Record account (you can register for this with a Medicare number or an Individual Healthcare Identifier).

How your information is used

For information on how your personal details are collected, stored and used, visit www.health.gov.au/using-our-websites/privacy/privacy-notice-for-covid-19-vaccinations.

On the day you have your vaccine

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

- have had an allergic reaction, particularly a severe allergic reaction (anaphylaxis), to:
  - a previous dose of a COVID-19 vaccine
  - an ingredient of a COVID-19 vaccine
  - other vaccines or medications
- are immunocompromised. This means that you have a weakened immune system that makes it harder for you to fight diseases. You can still have a COVID-19 vaccine but talk to your doctor about when is the best time to get your vaccine. This will depend on your condition and your treatment.

Consent Checklist

Yes	No	
☐	☐	Have you had an allergic reaction to a previous dose of a COVID-19 vaccine?
☐	☐	Have you had anaphylaxis to another vaccine or medication?
☐	☐	Have you had a serious adverse event, that following expert review by an experienced immunisation provider or medical specialist was attributed to a previous dose of a COVID-19 vaccine (and did not have another cause identified)?
☐	☐	Have you ever had mastocytosis (a mast cell disorder) which has caused recurrent anaphylaxis?
☐	☐	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 7 days?

For more information, see https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/advice-for-providers/tts

Yes No Relevant only for those receiving Pfizer :

☐ ☐ Have you been diagnosed with myocarditis and/or pericarditis after a previous dose of Pfizer or Moderna?

☐ ☐ Have you had myocarditis or pericarditis within the past three months?

☐ ☐ Do you currently have acute rheumatic fever or acute rheumatic heart disease?

☐ ☐ Do you have severe heart failure?

If you answered **Yes** to any of the above questions, you may still be able to receive Pfizer or Moderna, however you should talk to your GP, immunisation specialist or cardiologist first to discuss the best timing of vaccination and whether any additional precautions are needed.

After the last covid vaccine, which of the following side effects did you experience? Please tick.

☐ Pain or swelling at injection site

☐ Tiredness

☐ Headache

☐ Muscle pain

☐ Fever and chills

☐ Joint pain

☐ Nil side effects

☐ Redness at the injection site

☐ Nausea

☐ Enlarged lymph nodes

☐ Feeling unwell

☐ Pain in limb

☐ Insomnia

☐ Itching at the injection site

Patient information

Name:	
Medicare number:	
Individual Health Identifier (IHI) if applicable:	
Date of birth:	
Address:	
Phone contact number:	
Email address:	
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 I have none of the above conditions apply to me, or I have discussed these conditions and any other special circumstances with my regular health care provider and/or vaccination provider.

☐ I agree to receive a course of COVID-19 vaccine / I agree to receive a booster of COVID-19 vaccine

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

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

Parent/guardian/substitute decision-maker's name:	
Parent/guardian/substitute decision maker's signature:	
Date:	