



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).

Last updated: 30 July 2021

About COVID-19 vaccination

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

There are two brands of vaccine in use in Australia. Both are effective and safe. Comirnaty (Pfizer) vaccine is preferred over COVID-19 Vaccine AstraZeneca for adults under 60 years of age.

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 (thrombosis) with low blood platelet levels (thrombocytopenia) has been reported following vaccination with the COVID-19 Vaccine AstraZeneca. This is not seen after Comirnaty (Pfizer) vaccine. For further information on the risk of this rare condition refer to the [Patient information sheet on AstraZeneca COVID-19 vaccine and thrombosis with thrombocytopenia syndrome \(TTS\)](#).

Tell your healthcare provider if you have any side effects after vaccination that 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. 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.

Name:

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 the information you provide is used

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

If you are receiving your vaccination in a Pharmacy, the Pharmacy is required to disclose some of your personal information to the Pharmacy Programs Administrator. This is so the Pharmacy can claim payment from the Australian Government. More information about why this is required and the information disclosed is provided at the link above.

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.

Name:	
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Consent Checklist

- | 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"/> | Have you had a serious adverse event, that following expert review was attributed to a previous dose of a COVID-19 vaccine? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had mastocytosis which has caused recurrent anaphylaxis? |
| <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 only for those receiving **Pfizer - Comirnaty**:*

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had myocarditis or pericarditis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you currently have, or have you recently had acute rheumatic fever or endocarditis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have congenital heart disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | For people under 30 years of age: do you have dilated cardiomyopathy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have severe heart failure? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a recipient of a heart transplant? |

Patient information

Name:	
Date of birth:	
Address:	
Phone contact number:	
e-mail:	
Gender:	

Are you Aboriginal and/or Torres Strait Islander?

- Yes, Aboriginal only
 Yes, Torres Strait Islander only

Name:	
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- 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:	

For provider use:

Dose 1:

Date vaccine administered:	6/10/2021
Time received:	
COVID-19 vaccine brand administered:	Pfizer Vaccination : Comirnaty
Batch no:	FH0160
Site of vaccine injection:	L / R deltoid
Name of vaccination service provider:	Tania / Michelle/ Laura

Name:	
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