

COVID 19 vaccine consent form

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.

The COVID-19 vaccination is free. You choose to have the vaccination or not.

To be vaccinated you will get a needle in your arm. You need to have the vaccination two times on different days. There are different brands of vaccine. You need to have the same brand of vaccine both times.

Medical experts have studied COVID-19 vaccines to make sure they are safe. Most side effects are mild and don't last for long. As with any vaccine or medicine, there may be rare and/or unknown side effects.

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, if your state or territory has advised you should
- 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

Patient information

Name:	
Date of birth:	
Address:	
Phone contact number:	
Email:	Newsletter opt out <input type="checkbox"/>

Questionnaire before receiving your COVID 19 vaccine:

Y/N	
	Do you have any serious allergies, particularly anaphylaxis, to anything, or carry or have been prescribed an adrenaline autoinjector (EpiPen)?
	Have you had an allergic reaction after being vaccinated before?
	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 (having a baby) or think you might be pregnant?
	Are you planning to get pregnant?
	Are you breastfeeding?
	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?
	Do you have a history of fainting when having a vaccine or blood test?
	Do you have a mast cell disorder?
	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?

Please talk to your doctor if you have any questions or concerns before getting your COVID-19 vaccination.

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: _____ Date: _____

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

Legal guardian/substitute decision-maker's name: _____ Date: _____

Legal guardian/substitute decision maker's signature: _____ Date: _____

Office Use:

Patient has completed the above questionnaire.

The provided information above has been checked by the Practice Nurse or Doctor before vaccinating.

A post vaccination information sheet has been given to patient.

The patient has been given a date and time for the second dose.