

## Consent form for Children's Pfizer COVID-19 vaccination

### Parents/Guardians and child must be ready within a few minutes window

Our immunisation schedule is tight due to high demand. You must be with your child and have them prepared to receive the vaccine within a few minutes. If you miss this window then we may have to delay you by hours or reschedule for another day.

### Questionnaire to be filled by parent/guardian

Yes No

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Is your child between 5 and 11 years old (inclusive)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child recently been sick with a cough, sore throat or fever, or been feeling unwell in any way?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had <u>COVID-19</u> before?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had a <u>COVID-19</u> vaccination before?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child received any other vaccination in the last 14 days?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any serious allergies, particularly anaphylaxis, to anything, or carry or have been prescribed an adrenaline <u>autoinjector</u> (EpiPen)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had a serious reaction to a vaccine or medication?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child have a weakened immune system (immunocompromised) or any immune disorders?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child have a bleeding disorder or other blood disorder?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medicine to thin their blood (an anticoagulant therapy)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child ever had any problems with their heart?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had cerebral venous sinus thrombosis (blood clots in brain) in the past?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had heparin-induced thrombocytopenia (low platelets from heparin) in the past?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a parent/guardian/substitute decision maker who has the authority to provide consent for vaccination on behalf of this child?                           |

**Please talk to your doctor if you have any questions or concerns, before your child receives their COVID-19 vaccination and before signing this consent form**

**Child's information:**

Name:	
Date of birth:	
Address:	
Medicare number:	

**Is your child Aboriginal and/or Torres Strait Islander?**

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

**Emergency contact**

Name:	
Relationship to child:	
Phone contact number:	

**Consent to receive COVID-19 vaccine:**

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

Legal guardian/substitute decision-maker's <b>name</b> :	
Legal guardian/substitute decision maker's <b>signature</b> :	
Date:	