

Consent form for Comirnaty (Pfizer) COVID-19 vaccination

On the day you receive your vaccine:

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

- Have any **allergies**, particularly anaphylaxis (a severe allergic reaction). Have you ever had an allergic reaction to a COVID19 or other vaccine?
- If you have an **EpiPen** or have had one before.
- If you are **immunocompromised**. This means that you have a weakened immune system that may make it harder for you to fight infections and other diseases.

Yes No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had an allergic reaction after being vaccinated before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you 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"/> | Have you had <u>COVID-19</u> 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 (having a baby) or think you might be pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you breastfeeding? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been sick with a cough, sore throat, fever or feeling sick in another way? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a <u>COVID-19</u> vaccination before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have received any other vaccination in the last 7 days? Example: Flu Vaccine. |
| <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 ever had acute rheumatic fever or endocarditis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have congenital heart disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 the recipient of a heart transplant? |

Please talk to your doctor if you have any questions or concerns before getting your COVID-19 vaccination and before signing this consent form

Patient information:

Name:	
Date of birth:	
Address:	
Phone contact number:	
email:	

Are you 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

Next of kin (in case of emergency):

Name:	
Phone contact number:	

Consent to receive COVID-19 vaccine:

- I confirm I have received & 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 or vaccination provider
 I agree to receive a course of COVID-19 vaccine (two doses of the same vaccine)

Sign here OR below:

Patient's signature:	
Date:	

OR:

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

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