Your Doctors™

Consent form for 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). An allergy is when you come near, or in contact with, something and your body reacts to it and you get sick very quickly. This may include things like an itchy rash, your tongue getting bigger, your breathing getting faster, you wheeze or your heart beating faster.
- 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. Sometimes a disease like diabetes or cancer can cause this or certain medicines or treatments you take, such as medicine for cancer.

Yes	No	
❑	❑	Are you under 50 years of age?
❑	❑	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 feeling sick in another way?
❑	❑	Have you had a COVID-19 vaccination before?
❑	❑	Have received any other vaccination in the last 14 days?
❑	❑	Have you had cerebral venous sinus thrombosis (blood clots in brain) in the past?
❑	❑	Have you had heparin-induced thrombocytopenia (low platelets from heparin) in the past?

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:	
e-mail:	

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

Nexy 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 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:	