Australian Government

RESOLVE MEDICAL CENTRE

COVID-19 VACCINATION

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).

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 & DOB:	

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 www.health.gov.au/covid19-privacy.

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.

Yes	No	
☐	☐	Have you had an allergic reaction to a previous dose of a COVID-19 vaccine?
☐	☐	Have you had anaphylaxis to another vaccine or medication?
☐	☐	Do you have a mast cell disorder?
☐	☐	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?*
☐	☐	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 7 days?
Relevant for AstraZeneca COVID-19 vaccine only:		
☐	☐	Have you ever had cerebral venous sinus thrombosis? *
☐	☐	Have you ever had heparin-induced thrombocytopenia? *
☐	☐	Have you ever had blood clots in the abdominal veins? *
☐	☐	Have you ever had antiphospholipid syndrome associated with blood clots? *
☐	☐	Are you under 60 years of age? *

* If Comirnaty is not available, AstraZeneca COVID-19 vaccine can be considered for people in these groups, if the benefits of vaccination outweigh the risk. For more information refer to the: 'Patient information sheet on thrombosis with thrombocytopenia syndrome (TTS)'

Name & DOB:	

Patient information

Name:	
Medicare number:	
Individual Health Identifier (IHI) if applicable:	
Date of birth:	
Address:	
Phone contact number:	
e-mail:	
Gender:	
Language spoken at home:	
Country of birth:	

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

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 the AstraZeneca COVID-19 vaccination
- ☐ **For patients under the age of 60** - I confirm that I understood the information provided to me on the AstraZeneca COVID-19 vaccination and the age recommendation, however I am making an informed decision to have the AstraZeneca vaccine as my COVID-19 course.
- ☐ I confirm that none of the listed conditions 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 & DOB:	
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:	

Dose 1: Have you received any other immunisation in the last 7 days? YES ☐ NO ☐

Provider Use: Date & Time Vaccine Given: Brand Administered: Batch No & Expiry Date: Injection Site: Vaccine Provider:	

Dose 2: Have you received any other immunisation in the last 7 days? YES ☐ NO ☐

Signature:_____ Date:_____

Provider Use: Date & Time Vaccine Given: Brand Administered: Batch No & Expiry Date: Injection Site: Vaccine Provider:	