COVID-19 VACCINATION

Consent Checklist

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?
☐	☐	Have you had a serious adverse event, that following expert review was attributed to a previous dose of a COVID-19 vaccine?
☐	☐	Have you ever had mastocytosis which has caused recurrent anaphylaxis?
☐	☐	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 only for those receiving **AstraZeneca** COVID-19 vaccine:*

☐	☐	Have you ever been diagnosed with capillary leak syndrome?
☐	☐	Have you ever had major venous and/or arterial thrombosis in combination with thrombocytopenia, including diagnosed Thrombotic Thrombocytopenic Syndrome (TTS), following a previous dose of a COVID-19 vaccine?
☐	☐	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 (splanchnic veins)? *
☐	☐	Have you ever had antiphospholipid syndrome associated with blood clots? *
☐	☐	Are you under 60 years of age? *

* Comirnaty is the preferred vaccine for people in these groups but if not available, AstraZeneca COVID-19 vaccine can be considered if the benefits of vaccination outweigh the risk.

*Relevant only for those receiving **Comirnaty (Pfizer)**:*

☐	☐	Have you ever had myocarditis or pericarditis?
☐	☐	Do you currently have, or have you recently had acute rheumatic fever or endocarditis?
☐	☐	Do you have congenital heart disease?
☐	☐	For people under 30 years of age: do you have dilated cardiomyopathy?
☐	☐	Do you have severe heart failure?
☐	☐	Are you a recipient of a heart transplant?

Patient information

Name:	
Date 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 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:	
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:	

For information on how your personal details are collected, stored and used visit https://www.health.gov.au/using-our-websites/privacy/privacy-notice-for-covid-19-vaccinations.

Last updated: 3 August 2021