Consent form for COVID-19 vaccination

About COVID-19 vaccination

People who have a COVID-19 vaccination have a much lower chance of getting sick from the disease called COVID-19.

The COVID-19 vaccination is free. You choose to have the vaccination or not.

To be vaccinated you will get a needle in your arm. You need to have the vaccination two times on different days. There are different brands of vaccine. You need to have the same brand of vaccine both times. 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 and don't last for long. As with any vaccine or medicine, there may be rare and/or unknown side effects.

You can also tell your healthcare provider if you have any side effects like a sore arm, headache, fever or something else. If you have a side effect that worries you, please call your doctor. You may be contacted within the week after receiving the vaccine to see how you are feeling after vaccination.

Some people may still get COVID-19 after vaccination. So 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, if your state or territory has advised you should
- stay home if you are unwell with cold or flu-like symptoms and arrange to get a COVID-19 test.

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 is the information you provide at your appointment used

For information on how your personal details are collected, stored and used visit https://www.health.gov.au/covid19-vaccines

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 Epi Pen 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.

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Patient Information **Dose 1 or 2** (office use)

Surname: First name: Date of birth:

Address:

Phone number: Medicare Card Number: Ref no:

email: Gender: Male / Female / Other

Next of kin (in case of emergency) Name: Phone:

Are you Aboriginal and / or Torres Strait Islander?

- ☐ No ☐ Prefer not to answer
- ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander

Questions: Please answer the following questions:
Please talk to your doctor if you have any questions or concerns before getting your COVID-19 vaccination.

Yes	No	
		Do you have any serious allergies, particularly anaphylaxis, to anything, or carry prescribed adrenaline autoinjector (Epipen)?
		Have you had an allergy reaction after being vaccinated before?
		Do you have a bleeding disorder (such as heparin induced thrombocytopenia or idiopathic thrombocytopenic purpura)?
		Do you suffer from a clotting disorder such as CVST (central venus sinus thrombosis)?
		Do you take any medicine to thin your blood (an anticoagulant therapy)?
		Do you have a mast cell disorder?
		Do you have a weakened immune system (immunocompromised)?
		Have you had COVID-19 before?
		Have you had a COVID-19 vaccination before?
		Have you received any other vaccination in the last 14 days?
		Are you pregnant or do you think you might be pregnant?
		Are you breastfeeding?
		Have you been sick with a cough, sore throat, fever or are feeling sick in another way?

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 (two doses of the same vaccine)

Patient name:____

Patient signature: ____

Date: / /

I am the patient's legal guardian or legal 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 Provider use: **Name:** **DOB:**

Dose 1:	Date vaccine administered	
	Time received	
	COVID-19 vaccine brand administered	
	Batch number	
	Serial number	
	Site of vaccine injection	
	Name of vaccination service provider	

Dose 2:	Date vaccine administered	
	Time received	
	COVID-19 vaccine brand administered	
	Batch number	
	Serial number	
	Site of vaccine injection	
	Name of vaccination service provider	