**COVID-19 Vaccination**

**Consent Form**

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. This includes if you have had an EpiPen at any time.
* 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. 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? |
|  |  | Have you had COVID-19 before? |
|  |  | Do you have a mast cell disorder?  |
|  |  | 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 you feeling sick in another way? |
|  |  | Have you had a COVID-19 vaccination before? |
|  |  | Have you received any other vaccination in the last 7 days? |
|  |  | 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? 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? |

\*Cominarty (Pfizer) 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. For more information refer to the [Patient information sheet on thrombosis with thrombocytopenia syndrome (TTS)](https://www.health.gov.au/sites/default/files/documents/2021/05/patient-information-sheet-on-astrazeneca-covid-19-vaccine-and-thrombosis-with-thrombocytopenia-syndrome-tts.pdfhttps%3A/www.health.gov.au/sites/default/files/documents/2021/05/patient-information-sheet-on-astrazeneca-covid-19-vaccine-and-thrombosis-with-thrombocytopenia-syndrome-tts.pdf)

|  |  |
| --- | --- |
| Name: |  |
| Date of birth: |  |
| Address: |  |
| Phone number: |  |
| Email: |  |
| Gender: |  |

**Patient Information**

 **Consent to receive COVID-19 vaccine**

|  |  |
| --- | --- |
|  | I confirm I have received and understood information provided to me on the 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 understand for full immunity it is important to receive 2 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:  |  |