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

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.

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

Patient information

Name:	
Date of birth:	
Address:	
Phone contact number:	
e-mail:	
Gender:	

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?
☐	☐	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?

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:	