

# Consent form for COVID-19 vaccination

## Patient Information:

Surname:		First Name		
Birth Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____		Date of Birth: Day:	Month:	Year:
Street Address:				
Suburb:		State:	Postcode:	
Email:				
Phone Number:				
Medicare Card Number:		Ref #:	Exp Date:	
Are you Aboriginal or Torres Strait Islander? No <input type="checkbox"/> Yes <input type="checkbox"/> _____				
Next of Kin:		Phone Number:	Relationship:	
Emergency Contact:		Phone Number:	Relationship:	
<input type="checkbox"/> Tick if same as Next Of Kin				

## 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. \*See "After your Covid-19 vaccination" information sheet for more information.** If you have a side effect that worries you, please call your doctor.

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
- My Health Record account.

## 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.

- Yes  No Do you have any serious allergies, particularly anaphylaxis, to anything, or carry or have been prescribed an adrenaline autoinjector (EpiPen)?
- Yes  No Have you had an allergic reaction after being vaccinated before?
- Yes  No Have you had COVID-19 before?
- Yes  No Do you have a bleeding disorder?
- Yes  No Do you take any medicine to thin your blood (an anticoagulant therapy)?
- Yes  No Do you have a weakened immune system (immunocompromised)?
- Yes  No Are you pregnant (having a baby) or think you might be pregnant?
- Yes  No Are you planning to get pregnant?
- Yes  No Are you breastfeeding?
- Yes  No Have you been sick with a cough, sore throat, fever or are feeling sick in another way?
- Yes  No Have you had a COVID-19 vaccination before?
- Yes  No Have received any other vaccination in the last 14 days?

**\*\* Please talk to your doctor if you have any questions or concerns before getting your COVID-19 vaccination\*\***

## Consent to receive COVID-19 vaccination:

- 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: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's signature: \_\_\_\_\_

- I am the patient's legal guardian or legal substitute decision-maker, and agree to COVID-19 vaccination of the patient named above

Legal guardian/substitute decision-maker's name: \_\_\_\_\_

Legal guardian/substitute decision maker's signature: \_\_\_\_\_

Date: \_\_\_\_\_