# Consent to receive COVID-19 vaccine - 2nd & subsequent dose

**Name:** **Sex:** **Our Ref:** **Date of birth:**

**Address:**

**Medicare No.:** **Contact No.: Hm:** **Mob:**

**Next of kin (in case of emergency): Name:** **Contact No.:**

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.

| 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? |
| ☐ | ☐ | Do you have a mast cell disorder? |
| ☐ | ☐ | Have you had COVID-19 infection? |
| ☐ | ☐ | 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? |

## I agree to receive the 2nd and/or subsequent dose of Covid 19 vaccination

Patient's signature: _____ Date: _____

1st dose: ____ / ____ / ____ Brand: _____

2nd dose: ____ / ____ / ____ Brand: _____