On the day you receive your vaccine

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.
- 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?
☐	☐	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?

Relevant for AstraZeneca COVID-19 vaccine only:

☐	☐	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? *

Relevant only for those receiving Comirnaty:

☐	☐	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?

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

* Comirnaty 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.

Patient information

Name: ______________________________ Our Ref:

Medicare number: ____

Date of birth: ____

Address: ____

Phone contact number: Hm: __________________ Mob: _____________________

e-mail:

Sex:

Are you Aboriginal and/or Torres Strait Islander?

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

Next of kin (in case of emergency):

Name:

Phone contact number:

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 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: _______________