PLENTY ROAD MEDICAL CENTRE
Plenty Road Medical Centre atf Plenty Road Medical Centre Unit Trust
ABN 53 175 477 188

Consent form for COVID-19 vaccination

About COVID-19 vaccination

Before completing this form make sure you have read the information sheet on the vaccine you will be receiving, either COVID-19 Vaccine AstraZeneca or Cominarty (Pfizer)

People who have a COVID-19 vaccination have a much lower chance of getting sick from the disease called COVID-19.

There are two brands of vaccine in use in Australia. Both are effective and safe. Cominarty (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 on 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.

A very rare side effect of blood clotting (thrombosis) with low blood platelet levels (thrombocytopenia) has been reported following vaccination with the COVID-19 Vaccine AstraZeneca. This is not seen after Cominarty (Pfizer) vaccine. For further information on the risk of this rare condition refer to the Patient information sheet on AstraZeneca COVID-19 vaccine and thrombosis with thrombocytopenia syndrome (TTS).

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. 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

MyHealthRecord account

How is the information you provide at your appointment used

For information on how your personal details are collected, stored and used visit https://www.health.gov.au/covid19-privacy

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 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.

Consent form for COVID-19 Vaccination

Patient Information	**Dose 1 or 2** (office use)
Name:	Date of birth:
Address:	
Phone number:	Medicare Card Number: Ref number : Exp date:
Email:	Gender: Male / Female / Other
Next of kin (in case of emergency) Name:	Phone:

Are you Aboriginal and / or Torres Strait Islander?

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

Questions: Please answer the following questions:
Please talk to your doctor if you have any questions or concerns before getting your COVID-19 vaccination.

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 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 (having a baby) or think you might be 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 14 days?

Relevant for AstraZeneca COVID-19 Vaccine only

*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. For more information refer to the: Patient information sheet on thrombosis with thrombocytopenia syndrome (TTS).

Yes	No	
		Have you had cerebral venous sinus thrombosis in the past?
		Have you had heparin-induced thrombocytopenia in the past?
		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?

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 (two doses of the same vaccine)

Patient name:_____

Patient 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 / /

For Provider use:

Dose 1:	Date vaccine administered	
	Time received	
	COVID-19 vaccine brand administered	
	Batch number	
	Serial number	
	Site of vaccine injection	
	Name of vaccination service provider	

Dose 2:	Date vaccine administered	
	Time received	
	COVID-19 vaccine brand administered	
	Batch number	
	Serial number	
	Site of vaccine injection	
	Name of vaccination service provider	