CONSENT FOR COVID-19 VACCINATION - ADULT

PFIZER COMIRNATY JN.1 for 12 YEARS +

Australian Government

GLENWOOD MEDICAL PRACTICE

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T: 02 8824-8433 F: 02 8824-8477

Patient Information

NAME	
ADDRESS	
DATE OF BIRTH	**Gender**:
MEDICARE NUMBER	
PHONE NUMBER	
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
Dose Requested (Please circle)	**Dose 1 Dose 2 Dose 3 Dose 4** **Dose 5 Dose 6 Dose 7 Dose 8**

Consent to receive COVID-19 vaccine:

☐ I confirm I have received & 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 or vaccination provider.
☐ I agree to receive a course of COVID19 vaccines/ I agree to receive a booster of COVID19 vaccine.

Patient's name	
Patient's signature	Date:

☐ *I am the patient's legal guardian or legal substitute decision-maker & agree to COVID-19 vaccination of the patient named above.*

Legal guardian/substitute decision-makers name	
Legal guardian/substitute decision maker's signature	Date:
Next of kin (in case of emergency) Name	
Phone contact number:	

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YES	NO	CONSENT FOR COVID-19 VACCINATION
☐	☐	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 by an experienced immunisation provider or medical specialist was attributed to a previous dose of a COVID-19 vaccine (and did not have another cause identified)?
☐	☐	**Have you been positive with COVID-19 in the last 6 months?**
☐	☐	Have you ever had mastocytosis (a mast cell disorder) which has caused recurrent anaphylaxis?
☐	☐	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)?
☐	☐	Have you received any other vaccination in the last **7 days**?
☐	☐	Are you pregnant?*
☐	☐	Are you currently sick with a cough, sore throat, fever or feeling sick in another way?
☐	☐	**Have you had a COVID-19 vaccination in the last 6 months?**
☐	☐	Have you been diagnosed with myocarditis and/or pericarditis after a previous dose of Pfizer?
☐	☐	Have you had myocarditis and/or pericarditis within the past three months?
☐	☐	Do you currently have acute rheumatic fever or acute rheumatic heart disease?
☐	☐	Do you have severe heart failure?
☐	☐	Have you ever been diagnosed with capillary leak syndrome?*

 # Pfizer brands are the preferred vaccines for pregnant women in Australia. For more information. see: www.health.gov.au/initiativesand-programs/covid-19-vaccines/who-can-get-vaccinated/pregnant-women

^If you answered yes to any of these questions, you should talk to your immunisation provider about which vaccine is best for you, and to consider whether any additional precautions are needed.
For more information, see: www.health.gov.au/resources/publications/covid-19-vaccination-guidance-onmyocarditis-and-pericarditis-after-mrna-covid-19-vaccines