Consent Checklist - PLEASE CIRCLE THE VACCINE

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?
☐	☐	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 ever had mastocytosis (a mast cell disorder) which has caused recurrent anaphylaxis?
☐	☐	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? *
☐	☐	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 only for those receiving **AstraZeneca**:*

☐	☐	Have you ever been diagnosed with capillary leak syndrome?
☐	☐	Have had thrombosis (clotting) together with thrombocytopenia (low platelets) within 42 days after having a previous dose of AstraZeneca?
☐	☐	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 (splanchnic veins)? *
☐	☐	Have you ever had antiphospholipid syndrome associated with blood clots? *
☐	☐	Are you under 60 years of age? *

*Relevant only for those receiving **Pfizer** or **Moderna**:*

☐	☐	Have you been diagnosed with myocarditis and/or pericarditis after a previous dose of Pfizer or Moderna?
☐	☐	Have you had myocarditis 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?

If you answered **Yes** to any of the above questions, you may still be able to receive Pfizer or Moderna, however you should talk to your GP, immunisation specialist or cardiologist first to discuss the best timing of vaccination and whether any additional precautions are needed.

Given Name	Surname
Medicare number:	
Individual Health Identifier (IHI) if applicable:	
Date of birth:	
Address:	
Phone contact number:	
Email address:	
Gender:	
Language spoken at home:	
Country of birth:	

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 I have none of the above conditions apply to me, or I have discussed these conditions and any other special circumstances with my regular health care provider and/or vaccination provider.

☐ I agree to receive a course of COVID-19 vaccine / I agree to receive a booster of COVID-19 vaccine

Patient's name:	
Patient's signature:	
Date:	

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

Parent/guardian/substitute decision-maker's name:	
Parent/guardian/substitute decision maker's signature:	