# Consent form for COVID-19 Booster Vaccine

*Before completing this form make sure you have read the information sheet on the vaccine you will receiving, either COVID-19 Vaccine Comirnaty (Pfizer).* (Last updated: 2 June 2021)

## **About COVID-19 vaccination**

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

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.

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. 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,
* 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 [www.health.gov.au/covid19-privacy](http://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 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.

**Consent form for COVID-19 Vaccination**

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| **Patient Information Dose**  (office use)  |
| Name: Date of birth:  |
| Address: |
| Phone number: Medicare Card Number:  |
| 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
 |
| Language spoken at home:  |
| Country of birth :  |
| 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 COVID-19 vaccine?  |
|  |  | Have you had anaphylaxis to another vaccine or medication?  |
|  |  | Have you had COVID-19 before? |
|  |  | Do you have mast cell disorder? |
|  |  | 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 50 years of age? \* |

For more information refer to the: [[Patient information sheet on thrombosis with thrombocytopenia syndrome (TTS)](https://www.health.gov.au/resources/publications/patient-information-sheet-on-astrazeneca-covid-19-vaccine-and-thrombosis-with-thrombocytopenia-syndrome-tts)’](https://www.health.gov.au/resources/publications/covid-19-vaccination-information-on-covid-19-astrazeneca-vaccine)  **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 Booster dose of COVID-19

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: / /* I am the patient’s guardian or substitute decision-maker, and agree to COVID-19 vaccination of the patient named above.

Guardian / substitute decision-maker’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Guardian / substitute decision maker’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date / /  |
| **For Provider use:**

|  |  |  |
| --- | --- | --- |
| **Booster**  | Date vaccine administered |  |
|  | Time received  |  |
|  | COVID-19 vaccine brand administered |  |
|  | Batch number |  |
|  | Serial number |  |
|  | Site of vaccine injection |  |
|  | Name of vaccination service provider |  |

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