

COVID-19 VACCINE

Consent and Screening Form

PERSON TO BE VACCINATED

Before completing this form make sure you have read the information sheet on the COVID-19 vaccine you will be receiving, either Pfizer (Comirnaty), Moderna (Spikevax) or Novavax (Nuvaxovid).

First name..... Last name.....

Date of birth/...../..... Current age.....

Address.....

Suburb..... Postcode.....

Medicare number

Reference number

(If applicable) Individual Health Identifier (IHI) number

Are you: Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander Neither Prefer not to say

Mobile phone number..... Male Female Other Prefer not to say

Email.....

Name of next of kin (in case of emergency)..... Contact number.....

I confirm I have received and understood the information provided to me on COVID-19 vaccination including the risks and benefits of the vaccination and the risk of not being vaccinated. I have been given the opportunity to discuss this and any other specific circumstances with my immunisation provider. I am aware of possible side effects.

I CONSENT for the above named to receive the COVID-19 vaccine ticked below. I understand that consent can be withdrawn at any time prior to vaccination.

I understand that the information I provide during the consent process, and information related to any vaccines administered, will be stored electronically and/or in hard copy as a medical record, and may be used to assist in contact tracing purposes, monitoring and reporting on the vaccine rollout and other related purposes (further information about privacy available on request).

I consent to the disclosure of this information to staff involved in the provision of an immunisation service. I acknowledge that the vaccination record will be recorded on the Australian Immunisation Register where it will be stored on my Medicare account.

I understand that I may be contacted by SMS or email after receiving the vaccine to see how I am feeling after vaccination.

Signature of person consenting.....

Print name..... Date/...../.....

Relationship to person to be vaccinated (please circle):

Self / Parent / Legal Guardian / Person Responsible / Substitute Decision Maker

Signature of immunisation provider.....

Print name..... Date/...../..... Time Designation

Vaccine service provider.....

OFFICE USE ONLY: PLEASE TICK APPROPRIATE BOX FOR VACCINE DETAILS

YES Pfizer/BioNTech (Comirnaty™) **Batch number** **Dose 1** **Dose 2** **Dose 3/booster** **LA / RA**

Serial number

YES Novavax (Nuvaxovid™) **Batch number** **Dose 1** **Dose 2** **Dose 3/booster** **LA / RA**

Serial number

YES Moderna (Spikevax™) **Batch number** **Dose 1** **Dose 2** **Dose 3/booster** **LA / RA**

Serial number

OTHER (please specify) **Batch number** **Dose 1** **Dose 2** **Dose 3/booster** **LA / RA**

Serial number



First name..... Last name..... Date of birth/...../.....

PRE-VACCINATION CHECKLIST (to be completed prior to vaccination)

Have you had an allergic reaction to a previous dose of a COVID-19 vaccine?	YES	NO
Have you had anaphylaxis to another vaccine or medication?	YES	NO
Have you had a serious adverse event, that following expert review was attributed to a previous dose of a COVID-19 vaccine?	YES	NO
Have you ever had mastocytosis which has caused recurrent anaphylaxis?	YES	NO
Have you had COVID-19 before?	YES	NO
Have you received an anti-SARS-CoV-2 monoclonal antibody or convalescent plasma in the last 90 days?	YES	NO
Do you have a bleeding disorder?	YES	NO
Do you take any medicine to thin your blood (an anticoagulant therapy)?	YES	NO
Do you have a weakened immune system (immunocompromised)?	YES	NO
Are you pregnant?*	YES	NO
Have you been sick with a cough, sore throat, fever or are feeling sick in another way?	YES	NO
Have you had a COVID-19 vaccination before?	YES	NO
Have you had any other vaccine/s in the last 7 days?	YES	NO

*Pfizer and Moderna are the preferred vaccines for pregnant women. If these vaccines are not available, Novavax can be considered.

RELEVANT FOR PFIZER OR MODERNA COVID-19 VACCINE ONLY

Have you been diagnosed with myocarditis and/or pericarditis that is attributed to a previous dose of Pfizer or Moderna?	YES	NO
Have you had myocarditis, pericarditis or endocarditis within the past three months?	YES	NO
Do you currently have acute rheumatic fever or acute rheumatic heart disease?	YES	NO
Do you have severe heart failure?	YES	NO

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.

COMMENTS/CLINICAL NOTES