COVID-19 VACCINE
Consent and Screening Form

Government of South Australia
SA Health

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), AstraZeneca (Vaxzevria) or Moderna (Spikevax).

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

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

Address.....

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

Medicare number ☐☐☐☐ ☐☐☐☐☐☐ **Reference 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 I understand that consent can be withdrawn at any time prior to vaccination.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. 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** ☐ **LA / RA**
Serial number .....

☐ **YES** AstraZeneca (Vaxzevria®) **Batch number** ..... **Dose 1** ☐ **Dose 2** ☐ **LA / RA**
Serial number .....

☐ **YES** Moderna (Spikevax™) **Batch number** ..... **Dose 1** ☐ **Dose 2** ☐ **LA / RA**
Serial number .....

OTHER *(please specify)* **Batch number** ..... **Dose 1** ☐ **Dose 2** ☐ **LA / RA**
Serial number .....

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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
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

RELEVANT FOR ASTRAZENECA COVID-19 VACCINE ONLY

Have you ever been diagnosed with capillary leak syndrome?	☐ YES	☐ NO
Have had thrombosis (clotting) together with thrombocytopenia (low platelets) within 42 days after having a previous dose of AstraZeneca?	☐ YES	☐ NO
Have you ever had cerebral venous sinus thrombosis? *	☐ YES	☐ NO
Have you ever had heparin-induced thrombocytopenia? *	☐ YES	☐ NO
Have you ever had blood clots in the abdominal veins (splanchnic veins)? *	☐ YES	☐ NO
Have you ever had antiphospholipid syndrome associated with blood clots? *	☐ YES	☐ NO
Are you under 60 years of age? *	☐ YES	☐ NO

*** Pfizer or Moderna are the preferred vaccines for people in these groups. If these vaccines are not available, AstraZeneca can be considered if the benefits of vaccination outweigh the risks. (Refer to vaccine information sheets for further information.)**

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 six 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