COVID-19 Vaccine Consent Form

SURNAME: ______________________________________ (BLOCK CAPITALS)

FIRST NAME: ____________________________________ (BLOCK CAPITALS)

DATE OF BIRTH: ________/________/__________

The vaccines are currently not licenced for anyone under 16 years of age. You must be 16 years old or over at the time of vaccination, to be vaccinated.

PPSN (*VERY IMPORTANT*): |_____|_____|_____|_____|_____|_____|_____|_____|_____|

YOU *MUST* HAVE THIS TO BE VACCINATED   Some PPS numbers have 8 characters, some have 9

ADDRESS: ____ (BLOCK CAPITALS)

____ (BLOCK CAPITALS)

MOBILE NUMBER: ________–_________________________

EMAIL ADDRESS: ____ (BLOCK CAPITALS)

Please answer all of the following questions:

Question	Your Answer	*Are you eligible for the vaccine?*
Have you had anaphylaxis (serious systemic allergic reaction requiring medical intervention) following a previous dose of any vaccine or any of the constituents of the COVID-19 vaccines, including polyethylene glycol?	YES / NO	*If you answered **yes**, we are not equipped to care for you here should you have a reaction; it would be safer for you to be vaccinated in a hospital*
Have you been diagnosed with COVID-19 within the last 4 weeks?	YES / NO	*If you answered **yes**, you will **not** be eligible for vaccination until 4 weeks after your COVID-19 symptoms finish*
Have you had another vaccine within the last 14 days?	YES / NO	*If you answered **yes**, you will **not** be eligible for this vaccine until 14 days after your last vaccination*
Do you have a bleeding disorder or are you on anticoagulation therapy?	YES / NO	*This does not affect your eligibility, your vaccinator just needs to know*
Are you pregnant, less than 14 weeks?	YES / NO	*If you are pregnant, at less than 14 weeks gestation, you are **not** eligible for vaccination at this time*
Are you pregnant, more than 14 weeks?	YES / NO	*If you are more than 14 weeks pregnant and consenting to vaccination, please bring a letter from your obstetric care giver confirming you may receive the vaccine*

Please Turn Over →

Please read the accompanying vaccine information leaflet then tick the appropriate boxes below:

YES

I have read and understand the vaccine information provided, including known side effects.

I understand the COVID-19 vaccine is not recommended during pregnancy.

I understand that I am giving consent for the administration of two doses of COVID-19 vaccine at the appropriate interval.

Yes, I give **consent** to be vaccinated against COVID-19.

YES

NO

I have read and understood the accompanying vaccine information provided, including the risks of not vaccinating.

No, I do **not** consent to be vaccinated against COVID-19.

NO

Signed: ___________________________________

Date: ______/_______/20_____

Have you filled in the other side? →

------------------------------------Vaccine Centre use only------------------------------------

Administered by: _______________________________ (BLOCK CAPITALS)

Signature: _______________________________ Date: _____/_____/20___

Intramuscular vaccination site: (Right) Deltoid ____

(Left) Deltoid ____

Vaccine Brand: ______________________

Expiry Date: _____/_____/20___

Batch No: ___________________

Vaccine Centre: Main Street Townview