

prahran market clinic



COVID – 19 VACCINE CONSENT

Before you get vaccinated, tell the doctor or nurse giving you the vaccination if you:

- Have any allergies, 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. An allergy is when you come near or in contact with something and your body reacts to it and you get sick very quickly. This may include things like an itchy rash, your tongue getting bigger, your breathing getting faster, you wheeze or your heart beating faster.
- If you are immunocompromised. This means that you have a weakened immune system that may make it harder for you to fight infections and other diseases. Sometimes a disease like diabetes or cancer can cause this or certain medicines or treatments you take, such as medicine for cancer.

Yes No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any serious allergies, particularly anaphylaxis, to anything? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had an allergic reaction after being vaccinated before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a mast cell disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had COVID-19 before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a bleeding disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take any medicine to thin your blood (an anticoagulant therapy)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a weakened immune system (immunocompromised)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant or do you think you might be pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you breastfeeding? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been sick with a cough, sore throat, fever or are feeling sick in another way? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a COVID-19 vaccination before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have received any other vaccination in the last 14 days? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a confirmed medical history of cerebral venous sinus thrombosis (CVST) or a confirmed medical history of heparin induced thrombocytopenia? |

Please talk to your doctor if you have any questions or concerns before getting your COVID-19 vaccination.

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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 course of COVID-19 vaccine (two doses of the same vaccine)
- I understand my vaccine information will be uploaded electronically to AIR (Australia Immunisation Register).

Patient's name:	
Patient's 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:	