eastern shore doctors

Patient Consent form for COVID-19 Vaccination

Please read and complete both sides of this form.

Patient information

Name:														
Date of birth:					Phone number:									
Medicare number:														
Emergency contact:					Phone number:									
Are you Aboriginal or Torres Strait Islander: please tick applicable box	Prefer not to say		Yes, Aboriginal		Yes, Aboriginal and Torres Strait Islander		Torres Strait Islander only		No	

Before you get vaccinated, tell the person giving you the vaccination if you:

- Have any allergies, or have had a severe allergic reaction to a previous dose of a COVID-19 vaccine, or to other vaccines or medications.
- If you are immunocompromised (have a weakened immune system).

Please indicate below Yes or No to the following questions:

Yes	No	
☐	☐	Do you have any serious allergies, particularly anaphylaxis, to anything?
☐	☐	Have you had an allergic reaction after being vaccinated before?
☐	☐	Do you have a mast cell disorder?
☐	☐	Have you had COVID-19 before?
☐	☐	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 or do you think you might be pregnant?
☐	☐	Are you breastfeeding?
☐	☐	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 received any other vaccination in the last 14 days?
☐	☐	Have you had cerebral venous sinus thrombosis (a type of brain clot) in the past?
☐	☐	Have you had heparin-induced thrombocytopenia (a rare reaction to heparin treatment) in the past?

☐ Tick this box if you have specific questions or concerns you'd like to discuss with the doctor before getting your COVID-19 vaccination today.

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 confirm that I meet the current eligibility criteria for the COVID 19 vaccine

Please specify eligibility criteria met (i.e. Age) _____

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:	

For provider use:

Date vaccine administered:	
COVID-19 vaccine brand administered:	AstraZeneca
Batch no:	
Name of vaccination service provider:	
Signature of vaccination service provider:	

Provider checklist

☐ Consent form signed

☐ Side effects explained

☐ Batch/serial number recorded above

☐ Documented in Patient file/Uploaded to AIR

☐ Post-vaccination waiting time specified on After Your Vaccine Form