# BALWYN HEALTH CARE - Consent form for COVID-19 vaccination

Some People may still get Covid 19 after vaccination. You must still follow precautions afterwards, including masks, safe distancing, hand washing etc. Most side effects are mild. Experts advise it is safe.

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| **Patient Information Dose**  **1 or 2** (office use) | |
| Name: Date of birth: | |
| Address: | |
| Phone number: Medicare Card Number: | |
| email: Gender: Male / Female / Other | |
| Next of kin (emergency) Name: Phone: | |
| Are you Aboriginal and / or Torres Strait Islander? | YES NO |
| Have you read and understood the information leaflet provided by the practice | YES NO |
|  | |
| Please answer the following questions: Talk to your doctor if you have any questions or concerns   |  |  |  | | --- | --- | --- | | Yes | No |  | |  |  | Have you had an allergic reaction to a previous dose of COVID-19 vaccine? | |  |  | Have you had anaphylaxis to another vaccine or medication? | |  |  | Have you had COVID-19 before? | |  |  | Do you have mast cell disorder? | |  |  | 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? \* | |  |  | 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 you received any other vaccination in the last 7 days? | | *Relevant for AstraZeneca COVID-19 Vaccine only :* | | | |  |  | Have you ever had cerebral venous sinus thrombosis? | |  |  | Have you ever had heparin-induced thrombocytopenia? | |  |  | Have you ever had blood clots in the abdominal veins? | |  |  | Have you ever had antiphospholipid syndrome associated with blood clots? | |  |  | Are you under 50 years of age? |     **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 (two doses of the same vaccine)   Patient’s Name or  Guardian’s / Decision maker’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / / | |