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 AstraZeneca or Comirnaty (Pfizer).

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 I understand that consent can be withdrawn at any time prior to vaccination.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 **Batch number** ..... **Dose 1** ☐ **Dose 2** ☐ **LA / RA**

Serial number .....

☐ **YES** Moderna **Batch number** ..... **Dose 1** ☐ **Dose 2** ☐ **LA / RA**

Serial number .....

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

Serial number .....

.....

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 you ever had major venous and/or arterial thrombosis in combination with thrombocytopenia, including diagnosed Thrombotic Thrombocytopenic Syndrome (TTS), following a previous dose of a COVID-19 vaccine?	☐ 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

*** Comirnaty is the preferred vaccine for people in these groups but if not available, AstraZeneca COVID-19 vaccine can be considered if the benefits of vaccination outweigh the risk. For more information refer to fact sheet: Patient information sheet on thrombosis with thrombocytopenia syndrome (TTS)**

RELEVANT FOR COMIRNATY (PFIZER) COVID-19 VACCINE ONLY

Have you ever had myocarditis or pericarditis?	☐ YES	☐ NO
Do you currently have, or have you recently had acute rheumatic fever or endocarditis?	☐ YES	☐ NO
Do you have congenital heart disease?	☐ YES	☐ NO
For people under 30 years of age: do you have dilated cardiomyopathy?	☐ YES	☐ NO
Do you have severe heart failure?	☐ YES	☐ NO
Are you a recipient of a heart transplant?	☐ YES	☐ NO

COMMENTS/CLINICAL NOTES