COMO GP
YOUR MEDICAL HOME

245 Canning Hwy, COMO, WA 6152
Ph: (08) 6165 2444 Fax: (08) 6165 2448
Web: www.comogp.com.au

COVID-19 VACCINE CONSENT FORM

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

- Have had an allergic reaction, 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.
- Are immunocompromised. This means that you have a weakened immune system that may make it harder for you to fight infections and other diseases. You can still have a COVID-19 vaccine but may wish to consider the best timing of vaccination depending on your underlying condition and/or treatment.

PLEASE COMPLETE THE FOLLOWING CHECKLIST PRIOR TO RECEIVING THE VACCINE

KNOWN ALLERGIES:

Yes No

□ □ Have you had an allergic reaction to a previous dose of a COVID-19 vaccine?
□ □ Have you had anaphylaxis to another vaccine or medication?
□ □ Have you had a serious adverse event reviewed by an experienced immunisation provider/medical specialist that was attributed to a previous dose of COVID-19 vaccine (and did not have another cause identified)?
□ □ Do you have a mast cell disorder (mastocytosis) which has caused recurrent anaphylaxis?
□ □ 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?
□ □ 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 vaccinations in the last 7 days?

PATIENT INFORMATION

Name:	
Medicare number:	
Date of birth:	
Address:	
Phone/Contact number:	
Email:	

PATIENT NAME: MEDICARE:

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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 booster of COVID-19 vaccine.

Name:	
Patient/Guardian Signature:	
Date:	

FOR PROVIDER USE

PREVIOUS DOSES:

Dose	Date	Vaccine
1		
2		
3		

BOOSTER Dose:

Date vaccine administered:	
Time received:	
COVID-19 brand administered	
Batch no. and expiry:	
Site of vaccination injection	**LEFT Deltoid** **RIGHT Deltoid**
Vaccination service provider:	

PATIENT NAME: MEDICARE: