COVID-19 Vaccination Consent Form – PFIZER VACCINE

Patient information

Name:	
Date of birth:	
Medicare number / IHI:	Ref No: Exp:
Contact phone number:	

Next of kin information:

Next of kin (in case of emergency):	
Name:	
Contact phone number:	

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?
☐ ☐ 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?
☐ ☐ Have you been sick with a cough, sore throat, fever or are unwell in another way?
☐ ☐ Have you had a COVID-19 vaccination before?
☐ ☐ Have you received any other vaccination in the last 7 days?
☐ ☐ Have you ever had myocarditis or pericarditis?
☐ ☐ Do you have, or recently had, acute Rheumatic Fever or Endocarditis?
☐ ☐ Do you have congenital heart disease?
☐ ☐ For people under 30 years of age: do you have dilated cardiomyopathy?
☐ ☐ Do you have severe heart failure?
☐ ☐ Are you a recipient of a heart transplant?

Consent to receive Pfizer COVID-19 vaccine

☐ I confirm I have received and understood information provided to me on the Pfizer 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 Pfizer)

Patient Signature: ………………………………………. **Date:** **2021**
OR

☐ I am the patient's guardian or substitute decision-maker, and agree to COVID-19 vaccination of the patient named above

Guardian Name: ………………………………………… Guardian Signature: …………………………………

Name:

Date of birth:

Provider use only:

Dose 1:

Date vaccine administered:	
Time received:	
COVID-19 vaccine brand administered:	
Batch no:	
Serial no:	
Site of vaccine injection:	
Name of vaccination service provider:	

☐ No reaction to first dose Covid-19 vaccine

☐ No other vaccines in the last 1 week

Dose 2:

Date vaccine administered:	
Time received:	
COVID-19 vaccine brand administered:	
Batch no:	
Serial no:	
Site of vaccine injection:	
Name of vaccination service provider:	