

COVID-19 Vaccination Consent Form – CHILDREN’S PFIZER

Patient information

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

Parent/Guardian

Name:	
Contact phone number:	

Yes No

- Has your child recently been sick with a cough, sore throat or fever, or been feeling unwell at all?
- Has your child had COVID-19 before?
- Has your child had a COVID-19 vaccination before?
- Has your child had a serious reaction to a vaccine or medicine?
- Does your child have a weakened immune system (immunocompromised) or any immune disorders?
- Does your child have a bleeding disorder or other blood disorder, or take any medicine to thin their blood?
- Has your child ever had any problems with their heart?
- Are you a parent/guardian who has the authority to provide consent for vaccination on behalf of this child?

Consent to receive COVID-19 vaccine

- I confirm I have understood the information provided to me regarding the COVID-19 vaccination for my child
- I confirm that none of the conditions above apply to my child or I have discussed these and/or any other special circumstances with our regular health care provider and/or vaccination service provider
- I agree to my child receiving a course of COVID-19 vaccine (two doses of the same vaccine)

Signed:

Date: / /2021

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 2 weeks

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:	