Kingscliff HEALTH

Suite 9, 38-42 Pearl St, Kingscliff, NSW, 2487
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reception@kingscliffhealth.com.au
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CONSENT FORM for COVID-19 VACCINATION ASTRAZENECA - ADMIN COPY

Before completing this form, please ensure you have read the information about COVID-19 Vaccine AstraZeneca on our website (print version available from our clinic) and that you satisfy all items on the 'before you make a booking' checklist.

Patient Information

Name:	
Date of birth:	
Medicare number:	
Sex:	
Address:	
Phone contact number:	
e-mail:	

Are you Aboriginal and/or Torres Strait Islander?

☐ Yes ☐ No ☐ Prefer Not to Answer

Next of kin (in case of emergency):	
Name:	
Phone contact number:	

Acknowledgement and Consent to SMS Appointment Reminders

I acknowledge that the practice will use contact details provided by me (as updated by me from time to time) to communicate with me and to notify me to remind me of upcoming appointment dates with the practice as well as allowing appointment confirmation. To the extent that the mobile number I have provided to this general practice is utilised by more than one patient, I understand and consent that all SMS and phone communications will be directed to that number.

Patient's signature:	
Date:	
Guardian/substitute decision-maker's name:	
Guardian/substitute decision maker's signature:	
Date:	

Privacy

For information on how your personal details are collected, stored and used visit https://www.health.gov.au/covid19-vaccines.

Before you get vaccinated, tell your vaccination provider if:

You have any allergies, particularly anaphylaxis (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.

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CONSENT FORM for COVID-19 VACCINATION ASTRAZENECA - PROVIDER COPY

Name:		Age:	

Please check the appropriate box to the following questions:

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, that following expert review was attributed to a previous dose of a COVID-19 vaccine?
☐	☐	Have you ever had mastocytosis which has caused recurrent anaphylaxis?
☐	☐	Do you have a bleeding disorder?
☐	☐	Are you pregnant?*
☐	☐	Have you had COVID-19 before?
☐	☐	Have you had a COVID-19 vaccination before?
☐	☐	Have you received any other vaccination in the last 7 days?
☐	☐	Have you been sick with a cough, sore throat, fever or are feeling sick in another way?
☐	☐	Do you take any medicine to thin your blood (an anticoagulant therapy)?
☐	☐	Do you have a weakened immune system (immunocompromised)?
☐	☐	Have you ever been diagnosed with capillary leak syndrome?
☐	☐	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?
☐	☐	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 (splanchnic veins)? *
☐	☐	Have you ever had antiphospholipid syndrome associated with blood clots? *

* 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.

Consent to receive COVID-19 vaccine

☐ I confirm I have received and understood information provided to me on COVID-19 vaccination

☐ I agree to receive a course of COVID-19 vaccine (two doses of the same vaccine)

Patient's signature:	
Date:	
Guardian/substitute decision-maker's name:	
Guardian/substitute decision maker's signature:	
Date:	