Kingscliff HEALTH

Suite 9, 38-42 Pearl St, Kingscliff, NSW, 2487
02 6670 1400 02 6670 1499
reception@kingscliffhealth.com.au
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CONSENT FORM for COMIRNATY COVID-19 VACCINE (PFIZER) - ADMIN COPY

Before completing this form, please ensure you have read the information about Comirnaty COVID-19 vaccine (Pfizer) 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 COMIRNATY COVID-19 VACCINE (PFIZER) - 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 had myocarditis or pericarditis?
☐	☐	Do you currently have, or have you 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 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:	