Jindalee Care
MEDICAL PRACTICE

CONSENT FORM – COVID-19 VACCINATION

PATIENT NAME: _____

DATE OF BIRTH: _____

PLEASE CIRCLE: Aboriginal / Torres Strait Islander / Both / Non Indigenous

- **IMMUNISATION**: Immunisation is essential to protect individuals and others in the community, by increasing the general level of immunity and minimizing the spread of infection. All vaccines can cause side-effects. Usually, only mild effects may be experienced which disappear quickly (Lewandowsky, et. al., 2021; NCIRS, 2020).

RISKS AND POSSIBLE SIDE EFFECTS:

These may include:

- Muscle soreness, redness or swelling at the injection site
- Low grade fever
- General tiredness for a few days
- Headache (ATAGI, 2021b; Healthdirect, 2020)
- **Rare:** Anaphylaxis and blood clotting

	YES	NO
Do you have any serious allergies, particularly anaphylaxis, to anything, or carry or have been prescribed an adrenaline autoinjector (Epipen)?		
Have you had an allergic reaction after being vaccinated before?		
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 (having a baby) or think you might be pregnant?		
Are you planning to get pregnant?		
Are you breastfeeding?		
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 received any other vaccination in the last 14 days?		

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 course of COVID-19 vaccine (two doses of the same vaccine)

PATIENT/PARENT SIGNATURE: _____ **DATE:** _____

OFFICE USE ONLY

	DOSE 1	DOSE 2
COVID-19 vaccine brand		
Batch Number		
Serial Number		
Site of vaccine injection		

DR SIGN: _____ **DATE:**_____

RN/EN SIGN: _____ **DATE:**_____