Government of South Australia
SA Health

COVID-19 Vaccine Consent Form

PERSON TO BE VACCINATED

First name..... Last name.....

Date of birth ...../...../..... Current age.....

Address .....

Suburb..... Postcode.....

Medicare number ☐☐☐☐ ☐☐☐☐☐☐ **Reference number** ☐☐

☐ Aboriginal and Torres Strait Islander ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

Mobile phone number..... ☐ Male ☐ Female ☐ Other ☐ Prefer not to say

Email.....

I have read and understood the information given to me about vaccination, including the risks and benefits of the vaccination and the risk of not being vaccinated. I have been given the opportunity to discuss this with my immunisation provider. I am aware of possible side effects.

I CONSENT for the above named to receive the COVID -19 vaccine ticked below. I understand that consent can be withdrawn at any time prior to vaccination.

I understand that the information I provide during the consent process, and information related to any vaccines administered, will be stored electronically and/or in hard copy as a medical record. I consent to the disclosure of this information to staff involved in the provision of an immunisation service. I acknowledge that the vaccination record will be recorded on the Australian Immunisation Register where it will be stored on my Medicare account.

I understand that by consenting to receive the COVID-19 vaccine, I am also consenting to participate in active vaccine safety surveillance and that I will expect to receive a text message from AusVax Safety and may receive follow up from SA Health.

OFFICE USE ONLY: PLEASE TICK ☑ APPROPRIATE BOX FOR VACCINE DETAILS

☐ YES **Pfizer/BioNTech (Comirnaty™)** Batch number ..... Dose 1 ☐ Dose 2 ☐ LA / RA
Serial number .....

☐ YES **Astra Zeneca** Batch number ..... Dose 1 ☐ Dose 2 ☐ LA / RA
Serial number .....

☐ YES **Novavax** Batch number ..... Dose 1 ☐ Dose 2 ☐ LA / RA
Serial number .....

Other *(please specify)* Batch number ..... Dose 1 ☐ Dose 2 ☐ LA / RA
Serial number .....

.....

Signature of person consenting .....

Print name..... Date ...../...../.....

Relationship to person to be vaccinated (please circle):

Self / Parent / Legal Guardian / Person Responsible / Substitute Decision Maker

Signature of immunisation provider .....

Print name..... Date ...../...../..... Time ..... Designation .....

Organisation.....

COVID-19 VACCINATION

PRE-VACCINATION CHECKLIST

To be completed during the pre-vaccination screening with the person to be vaccinated.

Are you unwell today?	☐ YES	☐ NO
Do you have a disease that lowers immunity (e.g. leukaemia, cancer, HIV) or are having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, DMARDs [disease-modifying anti-rheumatic drugs], radiotherapy, chemotherapy)?	☐ YES	☐ NO
Are you receiving highly immunosuppressive therapy (e.g. bDMARDs [biologic disease-modifying anti-rheumatic drugs])?	☐ YES	☐ NO
Have you ever had a severe reaction following any vaccine?	☐ YES	☐ NO
Have you any severe allergies (to anything) particularly anaphylaxis?	☐ YES	☐ NO
Have you had any other vaccine(s) in the last two weeks?	☐ YES	☐ NO
Have you had an injection of immunoglobulin, or received any blood products, or a whole-blood transfusion within the past year?	☐ YES	☐ NO
Are you, or could you, be pregnant?	☐ YES	☐ NO
Have you had a history of Guillain–Barré syndrome?	☐ YES	☐ NO
Do you have a severe or chronic illness?	☐ YES	☐ NO
Do you have a bleeding disorder, or are you taking blood thinning medication?	☐ YES	☐ NO
Do you take any other medication?	☐ YES	☐ NO
Do you have a functioning spleen?	☐ YES	☐ NO
Have you ever fainted, or felt dizzy, when you have had an injection?	☐ YES	☐ NO

COMMENTS/CLINICAL NOTES