Consent form for Children's Pfizer COVID-19 vaccination

Parents/Guardians and child must be ready within a few minutes window

Our immunisation schedule is tight due to high demand. You must be with your child and have them prepared to receive the vaccine within a few minutes. If you miss this window then we may have to delay you by hours or reschedule for another day.

Questionnaire to be filled by parent/guardian

Yes	No	
❑	❑	Is your child between 5 and 11 years old (inclusive)?
❑	❑	Has your child recently been sick with a cough, sore throat or fever, or been feeling unwell in any way?
❑	❑	Has your child had COVID-19 before?
❑	❑	Has your child had a COVID-19 vaccination before?
❑	❑	Has your child received any other vaccination in the last 14 days?
❑	❑	Does your child have any serious allergies, particularly anaphylaxis, to anything, or carry or have been prescribed an adrenaline autoinjector (EpiPen)?
❑	❑	Has your child had a serious reaction to a vaccine or medication?
❑	❑	Does your child have a weakened immune system (immunocompromised) or any immune disorders?
❑	❑	Does your child have a bleeding disorder or other blood disorder?
❑	❑	Does your child take any medicine to thin their blood (an anticoagulant therapy)?
❑	❑	Has your child ever had any problems with their heart?
❑	❑	Has your child had cerebral venous sinus thrombosis (blood clots in brain) in the past?
❑	❑	Has your child had heparin-induced thrombocytopenia (low platelets from heparin) in the past?
❑	❑	Are you a parent/guardian/substitute decision maker who has the authority to provide consent for vaccination on behalf of this child?

Please talk to your doctor if you have any questions or concerns, before your child receives their COVID-19 vaccination and before signing this consent form

Child's information:

Name:	
Date of birth:	
Address:	
Medicare number:	

Is your child Aboriginal and/or Torres Strait Islander?

- ❑ Yes, Aboriginal only
- ❑ Yes, Torres Strait Islander only
- ❑ Yes, Aboriginal and Torres Strait Islander
- ❑ No
- ❑ Prefer not to answer

Emergency contact

Name:	
Relationship to child:	
Phone contact number:	

Consent to receive COVID-19 vaccine:

❑ I am the patient's legal guardian or legal substitute decision-maker & agree to COVID-19 vaccination of the patient named above.

Legal guardian/substitute decision-maker's **name:**	
Legal guardian/substitute decision maker's **signature:**	
Date:	