Your Doctors ™
Randwick

PFIZER

Consent form for Pfizer COVID-19 vaccination

On the day you receive your vaccine:

Before you get vaccinated, tell the person giving you the vaccination if you:

- Have any **allergies**, particularly anaphylaxis (a severe allergic reaction). Have you ever had an allergic reaction to a COVID19 or other vaccine?
- If you have an **EpiPen** or have had one before.
- If you are **immunocompromised**. This means that you have a weakened immune system that may make it harder for you to fight infections and other diseases.

Yes	No	
❑	❑	Have you had an allergic reaction after being vaccinated before?
❑	❑	Do you have any serious allergies, particularly anaphylaxis, to anything, or carry or have been prescribed an adrenaline autoinjector (EpiPen)?
❑	❑	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 breastfeeding?
❑	❑	Have you been sick with a cough, sore throat, fever or feeling sick in another way?
❑	❑	Have you had a COVID-19 vaccination before?
❑	❑	Have received any other vaccination in the last 7 days? Example: Flu Vaccine.
❑	❑	Have you ever had myocarditis or pericarditis?
❑	❑	Do you currently have, or have you ever had acute rheumatic fever or endocarditis?
❑	❑	Do you have congenital heart disease?
❑	❑	Do you have dilated cardiomyopathy?
❑	❑	Do you have severe heart failure?
❑	❑	Are you the recipient of a heart transplant?

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

Patient information:

Name:	
Date of birth:	
Address:	
Phone contact number:	
email:	

Are you 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

Next of kin (in case of emergency):

Name:	
Phone contact number:	

Consent to receive COVID-19 vaccine:

- ❑ I confirm I have received & 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 or vaccination provider
- ❑ I agree to receive a course of COVID-19 vaccine (two doses of the same vaccine)

Sign here OR below:

Patient's signature:	
Date:	

OR:

- ❑ I am the patient's parent/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:	