Government of **Western Australia**
Department of **Health**

COVID-19

COVID-19 Vaccination Consent Form

Before completing this form make sure you have read the information sheet on the COVID-19 vaccine you will be receiving.

Shade Circles Completely — Correct: ● Incorrect: ✓ ✗

Black Ink Only

Please print neatly in capital letters

E X A M P L E 1 2 3

Resident's Information: Provide information as completely as you can: all information will be kept confidential

First name

Last name

Date of birth (e.g. 05/08/1980) / /

Gender ○ Male ○ Female ○ Undisclosed ○ Non-binary

Do you identify as Aboriginal and/or Torres Strait Islander?

○ No ○ Yes, Aboriginal ○ Yes, Torres Strait Islander ○ Both ○ Prefer not to say

Telephone number (mobile preferred)

Email address

Medicare number (including individual reference number)

Residential address

Suburb Postcode

Next of kin (in case of emergency)

Name

Contact number

Health Questionnaire

Have you previously received the COVID-19 vaccine? ○ **Yes** ○ **No**

State Country

How many doses did you receive?

○ Dose 1 – Date received / /

○ Dose 2 – Date received / /

What brand of vaccine did you receive?

○ Pfizer-BioNTech ○ Oxford-AstraZeneca ○ Other

Health Questionnaire *(continued)*

Are you pregnant?	Yes / No
Have you had an allergic reaction to a previous dose of a COVID-19 vaccine?	Yes / No
Have you ever had anaphylaxis to another vaccine or medication?	Yes / No
Have you had any other serious adverse reaction to a previous dose of COVID-19 vaccine?	Yes / No
Do you have a bleeding disorder or are you currently receiving anticoagulant therapy (a blood thinner)?	Yes / No
Do you have a weakened immune system (immunocompromised)?	Yes / No
Do you have a mast cell disorder?	Yes / No
Have you received any other vaccination in the last 7 days?	Yes / No
Have you had COVID-19 infection before?	Yes / No
Have you been sick recently with a cough, sore throat, fever or are feeling sick in another way?	Yes / No

Relevant for AstraZeneca COVID-19 vaccine only

Are you under 60 years of age?	Yes / No
Have you had cerebral venous sinus thrombosis (a type of brain clot) in the past?	Yes / No
Have you had heparin-induced thrombocytopenia (a rare reaction to heparin treatment) in the past?	Yes / No
Have you had idiopathic splanchnic (mesenteric, portal and splenic) venous thrombosis (blood clot in the abdominal veins) in the past?	Yes / No
Have you ever had antiphospholipid syndrome associated with blood clots?	Yes / No
Have you had capillary leak syndrome in the past?	Yes / No
Have you ever had major venous and/or arterial thrombosis in combination with thrombocytopenia, including diagnosed Thrombotic Thrombocytopenic Syndrome (TTS), following a previous dose of a COVID-19 vaccine?	Yes / No

Relevant for Pfizer or Moderna COVID-19 vaccine only

Have you had recent (i.e. within the past 6 months) or current inflammatory cardiac illness e.g., myocarditis, pericarditis, endocarditis?	Yes / No
Do you currently have acute rheumatic fever or acute rheumatic heart disease?	Yes / No
For people under 30 years of age do you have dilated cardiomyopathy?	Yes / No
Do you have complex or severe congenital heart disease including single ventricle (Fontan) circulation?	Yes / No
Do you have severe heart failure?	Yes / No
Are you a recipient of a heart transplant?	Yes / No

Consent to receive COVID-19 vaccine

I confirm I have received and understood information provided to me on COVID-19 vaccination	Yes / No
I agree to receive a course of COVID-19 vaccine (two doses of the same vaccine)?	Yes / No
I give my permission for WA Health to contact me by email, telephone or SMS to monitor vaccine safety and effectiveness	Yes / No
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	Yes / No

Signature of person receiving vaccine

Legal guardian or legal substitute decision-maker details

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

First name

Last name

Date / /

Signature of legal guardian or legal substitute decision-maker

Email address

Office use only – verbal consent

Verbal consent for vaccination was given ○ **Yes** ○ **No**

Date / / **Time**

Signature of person giving consent

Consent person's name

Contact number **Relationship**

Data entry ○ AIR ○ webPAS ○ WINVAC ○ MMEX

Office use only – vaccine administration

Place vaccine batch label here

Vaccine serial number:

Injection site

○ Left arm ○ Right arm ○ Other

Dose number and administration date

○ Dose 1 – Date received / / ○ Dose 2 – Date received / /

Brand of vaccine

○ Pfizer-BioNTech ○ Oxford-AstraZeneca ○ Other

Signature of vaccinator

○ I hereby confirm that the details of the immunisation are correct. I acknowledge the integrity of this data and this may be integrated with other systems.

Name of vaccinator