Consent to Covid-19 Vaccination

We encourage patients to read as much information form the Department of Health Covid-19 vaccination website here.

TITLE SURNAME GIVEN NAMES

DATE OF BIRTH 31 December

SEX Male Female Other

ADDRESS POSTCODE Phone

- Yes No Do you have any serious allergies, particularly anaphylaxis, to anything, or have been prescribed an EpiPen?

Yes No Have you had an allergic reaction after being vaccinated before?

Yes No Have you had Covid-19 before?

Yes No Do you have a bleeding disorder?

Yes No Do you take any medicine to thin your blood (an anticoagulant therapy)?

Yes No Do you have a weakened immune system (immunocompromised)?

Yes No Are you pregnant or think you may be or planning to be or breastfeeding?

Yes No Have you been sick with a cough, sore throat, fever or are feeling sick in another way?

Yes No Have you had a Covid-19 vaccination before?

Yes No Have you received any other vaccination in the last 14 days?

Please talk to your doctor if you have any questions or concerns before getting your Covid-19 vaccination.

Consent to receive COVID-19 vaccine

I confirm I have received and understood information provided to me on Covid-19 vax;

I confirm that none of the above conditions apply, or I have discussed these or other special circumstances with my doctor or vaccination provider; and

I agree to receive a course of Covid-19 vaccine (two doses of the same vaccine).

Patients Name: Signature: Date: