**COVID-19 IMMUNISATION CONSENT FORM VERSION 6**

Name: Date of Birth:\_\_\_\_/\_\_\_\_/\_\_\_\_\_

Address: \_\_\_

Ph: Email: \_ \_\_\_

**PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS**

|  |  |  |
| --- | --- | --- |
| Are you pregnant or breast feeding? (*If you answer yes, please refer to Information about the COVID Vaccine)* | YES | NO |
| Have you had COVID-19 before? | YES | NO |
| Have you ever experienced an allergic reaction after a vaccination?  | YES | NO |
| Do you have an Epipen or have you ever experienced an Anaphylactic reaction or serious allergic reaction to anything?  | YES | NO |
| Are you taking any medication to thin your blood?  | YES | NO |
| Have you been diagnosed with a BLEEDING DISORDER?  | YES | NO |
| Have you been diagnosed with a MAST CELL DISORDER? | YES | NO |
| Have you been diagnosed with a medical condition / undergoing treatment that causes you to be IMMUNOCOMPROMISED? | 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 ever had blood clots in the abdominal veins? | YES | NO |
| Have you ever had antiphospholipid syndrome associated with blood clots? | YES | NO |
| Have you ever been diagnosed with capillary leak syndrome? | YES | NO |
| Are you under 60 years of age? | YES | NO |

**IF YOU ANSWERED YES TO ANY OF THESE QUESTIONS THE DOCTOR WILL DISCUSS THIS FURTHER WITH YOU DURING YOUR CONSULT**

**Patient Consent:**

* **I consent to receiving a COVID-19 Vaccine and have received and understood information provided to me on COVID-19 vaccination.**
* **I understand I will require 2 doses of the COVID-19 vaccine approximately 12 weeks apart.**
* **I understand that details regarding my vaccination will be sent to the Australian Immunisation Register.**

Signature: Date:\_\_\_\_/\_\_\_\_/\_\_\_\_

**Consent if you are the Guardian / Substitute Decision-Maker for the patient:**

Guardian / Substitute Decision-Maker’s Name:

Signature: Date:\_\_\_\_/\_\_\_\_/\_\_\_\_

***Please return this form back to us at your earliest convenience – we require this form back prior to booking a COVID Vaccine: Email:*** ***telehealth@eahc.com.au******. Fax: 8362 9716, or in person at one of our practices.***