Consent form for Pfizer (Comirnaty) COVID-19 vaccination

About COVID-19 vaccination

People who have a COVID-19 vaccination have a much lower chance of getting sick from COVID-19.

There are three brands of vaccine in use in Australia. All are effective and safe. Comirnaty (Pfizer) vaccine is the brand available at Castle Hill Medical Centre. You need to have two doses of the same brand of vaccine. The person giving you your vaccination will tell you when you need to have the second vaccination.

Medical experts have studied COVID-19 vaccines to make sure they are safe. Most side effects are mild. They may start on the day of vaccination and last for around 1-2 days. As with any vaccine or medicine, there may be rare and/or unknown side effects.

Cases of Myocarditis (inflammation of the heart muscle) and/or pericarditis (inflammation of the lining of the heart) have been reported as very rare side effects after mRNA COVID-19 vaccines (including Comirnaty (Pfizer)). Cases primarily occurred within 14 days after vaccination, more often in males aged under 30 years and after the second dose.

Tell your healthcare provider if you have any side effects after vaccination that you are worried about.

Some people may still get COVID-19 after vaccination. You must still follow public health precautions as required in your state or territory to stop the spread of COVID-19 including:

- keep your distance – stay at least 1.5 metres away from other people
- washing your hands often with soap and water, or use hand sanitiser
- wear a mask
- stay home if you are unwell with cold or flu-like symptoms, and arrange to get a COVID-19 test.

How the information you provide is used

For information on how your personal details are collected, stored and used visit https://www.health.gov.au/using-our-websites/privacy/privacy-notice-for-covid-19-vaccinations.

Vaccination providers record all vaccinations on the Australian Immunisation Register, as required by Australian law. You can view your vaccination record online through your:

- Medicare account
- MyGov account
- MyHealthRecord account.

On the day you receive your vaccine

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

- Have had a severe allergic reaction, particularly anaphylaxis to a previous dose of a COVID-19 vaccine, to an ingredient of a COVID-19 vaccine, or to anything else.

- 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. You can still have a COVID-19 vaccine, but may wish to consider the best timing of vaccination depending on your underlying condition and/or treatment.

Cominarty (Pfizer) Vaccine Patient Consent

Yes	No	
☐	☐	Have you had an allergic reaction to a previous dose of a COVID-19 vaccine?
☐	☐	Have you had anaphylaxis to another vaccine or medication?
☐	☐	Have you had a serious adverse event, that following expert review was attributed to a previous dose of a COVID-19 vaccine?
☐	☐	Have you ever had mastocytosis which has caused recurrent anaphylaxis?
☐	☐	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?
☐	☐	Have you been sick with a cough, sore throat, fever or other symptoms?
☐	☐	Have you had a COVID-19 vaccination before?
☐	☐	Have you received any other vaccination in the last 7 days?
☐	☐	Have you ever had myocarditis or pericarditis?
☐	☐	Do you have, or have had acute rheumatic fever or endocarditis?
☐	☐	Do you have congenital heart disease?
☐	☐	For people under 30 years of age: do you have dilated cardiomyopathy?
☐	☐	Do you have severe heart failure?
☐	☐	Are you a recipient of a heart transplant?

Patient information

Name:	
Medicare number:	
Date of birth:	
Address:	
Phone number:	
e-mail:	
Gender:	
Emergency Contact	
Emergency Contact Ph number	

☐ 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 and/or vaccination provider

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

Patient Name		Guardian Name	
Patient Signature		Guardian Signature	
Date			