Consent form for Pfizer COVID-19 Vaccination

Patient Information	**Dose ◯ 1 or ◯ 2**
Name:	Date of birth:
Address:	Gender: M ◯ F ◯
Medicare No.	

Questions: Please answer the following questions:
Please talk to your doctor if you have any questions or concerns before getting your COVID-19 vaccination.

Yes	No	
◯	◯	Have you had an allergic reaction to a previous dose of 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 are feeling sick in another way?
◯	◯	Have you had a COVID-19 vaccination before?
◯	◯	Have you received any other vaccination in the last 7 days?
Relevant for Pfizer COVID-19 Vaccine only :		
◯	◯	Have you ever had myocarditis or pericarditis?
◯	◯	Do you currently have, or have you recently 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?

Consent to receive Pfizer COVID-19 vaccine

- ☐ I confirm I have received and 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 service provider.
- ☐ I agree to receive a course of COVID-19 (two doses of the same vaccine)

Patient name: _____

Patient signature: _____

Date: / /