

COVID VACCINE Consent Checklist (30-07-2021)

Comirnaty (Pfizer)

- | Yes | No | |
|--------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had an allergic reaction to a previous dose of a COVID-19 vaccine/ had anaphylaxis to any other vaccine / have you had covid infection before |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had mastocytosis which has caused recurrent anaphylaxis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a bleeding disorder or take any medicine to thin your blood (an anticoagulant therapy)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a weakened immune system (immunocompromised)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been sick with a cough, sore throat, fever or are feeling sick in another way? Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a COVID-19 vaccination before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you received any other vaccination in the last 7 days? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had myocarditis or pericarditis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you currently have, or have you recently had acute rheumatic fever or endocarditis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have congenital heart disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | For people under 30 years of age: do you have dilated cardiomyopathy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have severe heart failure? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a recipient of a heart transplant? |

Consent to receive 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 vaccine (two doses of the same vaccine)

Last updated: 30 July 2021

Patient's name:	
Patient's signature:	
Date:	

- Please tick if you are signing as the legal guardian or carer for a patient receiving a course of the COVID-19 vaccine.