Consent form: Comirnaty (Pfizer) COVID-19 vaccination

Before completing this form we recommend you read the information sheet on the COMIRNATY (Pfizer) COVID-19 Vaccine on the Department of Health website (www.health.gov.au).

Patient Information

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

The COVID-19 vaccination is free and you can choose whether to have the vaccination or not.

There are three brands of vaccine in use in Australia. All are effective and safe. Comirnaty (Pfizer) or Moderna (Spikevax) are preferred over AstraZeneca (Vaxzevria) for adults under 60 years of age. Comirnaty (Pfizer) is approved for people aged 12 years and over and AstraZeneca is approved for people over the age of 18 years.

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. The more common side effects may include tenderness or pain at the injection site, headache, fever, fatigue, malaise, joint and muscle pain. As with any vaccine or medicine, there may be rare and/or unknown side effects.

A very rare side effect of blood clotting (thrombosis) with low platelet levels (thrombocytopenia) has been reported following vaccination with AstraZeneca. This is not seen after the Pfizer or Moderna vaccine.

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 Pfizer or Moderna). AstraZeneca is not associated with an increased risk of myocarditis/pericarditis.

Tell your healthcare provider if you have any side effects like a sore arm, chest pain, heart palpitations, shortness of breath, headache, fever, body aches or any symptom that is unusual for you. You may be contacted by SMS or email in the week after vaccination to see how you are feeling.

You will be asked to remain in the centre for 15 minutes observation after your vaccination, but if you have a previous history of anaphylaxis to a vaccine you will be required to wait for 30 minutes.

Some people may still get COVID-19 after vaccination, so you must still follow public health precautions as required in your State or Territory to stop the spread of COVID-19 including: physical distancing, wearing a mask, enhanced personal hygiene (hand washing/sanitising), staying at home if unwell with cold-like symptoms and promptly getting tested for COVID-19.

Vaccination providers record all vaccinations on the Australian Immunisation Register, as required by Australian Law. You can view this online in your Medicare/ MyGov/MyHealthRecord account.

For information on how your personal details are collected, stored and used visit https://www.health.gov.au/covid19-vaccines

On the day you receive your vaccine

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

- have had an allergic reaction, particularly anaphylaxis (a severe allergic reaction) to a previous dose of a COVID-19 vaccine, to an ingredient of a COVID-19 vaccine, or to any other vaccines or medications.
- are immune-compromised. This means that you have a weakened immune system that may make it harder for you to fight infections and other diseases.
- if you have a history of inflammatory cardiac illness (eg. pericarditis, myocarditis, endocarditis), acute rheumatic fever or severe heart failure.

Consent form for COVID-19 vaccination

IPN MEDICAL CENTRES

Sonic HealthPlus

Pre-Vaccination Screening

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 (a mast cell disorder) 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)? If so, which medication do you take? ______________________
☐	☐	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 elsewhere? If so, when: ____________ and which one? ☐ Astra Zeneca ☐ Pfizer ☐ Moderna ☐ Other, please specify: ____________
☐	☐	Have you received any other vaccination in the last 7 days?
☐	☐	Have you ever fainted after a vaccination or are you especially scared of needles?
☐	☐	Have you been diagnosed with myocarditis and/or pericarditis that is attributed to a previous dose of Pfizer or Moderna?
☐	☐	Have you had myocarditis, pericarditis or endocarditis within the past six months?
☐	☐	Do you currently have acute rheumatic fever or acute rheumatic endocarditis?
☐	☐	Do you have severe heart failure?

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 Comirnaty (Pfizer) 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 healthcare provider and/or vaccination service provider

☐ I agree to receive a Comirnaty (Pfizer) Covid-19 Vaccine today

Patient's name: ____________ Date of Birth: ____________

Patient's signature: ____________ Date: ____________

☐ I am the patient's legal parent, guardian or substitute decision maker, and agree to COVID-19 vaccination of the patient named above

Parent/guardian/substitute decision maker's name: ____________

Parent/guardian/substitute decision maker's signature: ____________ Date: ____________

Doctor Use Only

☐ Nurse to administer COMIRNATY (Pfizer) 0.3mL (following dilution) IM

Doctor's Name: ____________

Doctor's signature: ____________ Date: ____________