MediCo - Covid Vaccination - Astra Zenica

Name:
DOB:
Medicare Number:

	YES	NO
Do you have any serious allergies, particularly anaphylaxis, to anything?		
Have you had an allergic reaction after being vaccinated before?		
Do you have a mast cell disorder?		
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 received any other vaccination in the last 14 days?		
Have you had cerebral venous sinus thrombosis in the past?		
Have you had heparin-induced thrombocytopaenia in the past?		
Are you under 50 years of age?		
Any pressing committments that you can't afford to feel unwell for the next 48hrs		

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)

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

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

Guardian/substitute decision-maker's name:	
Guardian/substitute decision maker's signature:	
Date:	

1B eligibility (tick one):

	Age >=70
	Chronic disease
	Aboriginal >=55
	Healthcare worker
	Critical and high risk workers including defence, police, fire, emergency services and meat processing
	Obesity BMI>=40

Provider to complete:

Date vaccine administered:	
Time received:	
Time for discharge:	
COVID-19 vaccine brand administered:	Astra Zeneca
Batch no:	
Serial no:	
Site of vaccine injection:	
Name of vaccination service provider:	
ACIR updated	

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