



Ocean Wave Medical Covid Vaccine Clinic

87 Bowman Road, Caloundra Q 4551

Ph: 54919044

COMPLETE & BRING TO YOUR APPT

Consent form for COVID-19 vaccination

About COVID-19 vaccination

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

The COVID-19 vaccination is free. You choose whether to have the vaccination or not.

To be vaccinated you will get a needle in your arm. You need to have the vaccination two times on different days. There are different brands of vaccine. You need to have the same brand of vaccine both times. 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 and don't last for long. As with any vaccine or medicine, there may be rare and/or unknown side effects.

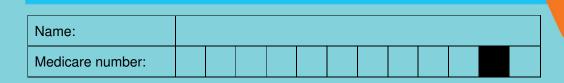
You can tell your healthcare provider if you have any side effects like a sore arm, headache, fever or any other side effect you are worried about. You may be contacted by SMS within the week after receiving the vaccine to see how you are feeling after vaccination.

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:

- 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, if your state or territory has advised that you should
- stay home if you are unwell with cold or flu-like symptoms and arrange to get a COVID-19 test.

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.



How is the information you provide at your appointment used

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 any allergies, 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 other vaccines or medications. An allergy is when you come near or in contact with something and your body reacts to it and you get sick very quickly. This may include things like an itchy rash, your tongue getting bigger, your breathing getting faster, you wheeze or your heart beating faster.
- If 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. Sometimes a disease like diabetes or cancer can cause this or certain medicines or treatments you take, such as medicine for cancer.

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 or do you think you might be pregnant?								
		Are you breastfeeding?								
		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?								
	e talk nation	to your doctor if you have any questions or concerns before getting your COVID-19.								
		atient to Ocean Wave Medical, please bring Patient Health Summary or Care eligibility check. Work ID for eligible workers will be required.								

Name:						
Medicare number:						

Patient information NEW PATIENT ARRIVE 10MINS PRIOR

Name:												
Medicare number:												
Date of birth:												
Address:												
Phone contact numb	er:											
e-mail:												
Sex:												
Regular Doctor												
Are you Aboriginal and/or Torres Strait Islander? Yes, Aboriginal only Yes, Torres Strait Islander only Yes Aboriginal and Torres Strait Islander No Prefer not to answer Ethnicity: Language other than English:												
Smoker - No or Yes or Ex smoker If Yes how many per day Alcohol - No or Yes If yes how many per week												
Next of kin (in case of	of emergence	y):										
Name:												
Phone contact numb	er:											
Consent to receive I confirm I have vaccination				od info	ormati	on pro	ovided	d to m	e on (COVI	D-19	
other special circ	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 receiv	e a course	of CO	VID-1	19 vac	cine (two do	oses o	of the	same	vaco	ine)	
Patient's name:												
Patient's signature:	Patient's signature:											
Date:				-			-		-			
	I am the patient's guardian or substitute decision-maker, and agree to COVID-19 vaccination of the patient named above											

Name:						
Medicare number:						

Guardian/substitute decision-maker's name:							
Guardian/substitute decision maker's signatur	e:						
Date:							
For provider use:							
CATEGORY DETERMINED BY DOCTOR:							
Phase 1B Eligibility	Over 70						
	Health Care Worker ABTSI over 55						
	Under 70 eligible health condition Critical & High Risk Workers- ID needed						
Phase 2A Eligibility	Adults over 50 years ABTSI over 18 to 54yr						
	Other High Risk Workers – ID needed						
Phase 2B Eligibility	Balance of adult population						
lose 1:							
Date vaccine administered:							
Time received:							
COVID-19 vaccine brand administered:							
Batch no:							
Serial no:							
Site of vaccine injection:							
Name of vaccination service provider:							
Pose 2							
Date vaccine administered:							
Time received:							
COVID-19 vaccine brand administered:							
Batch no:							
Serial no:							
Site of vaccine injection:							
Name of vaccination service provider:							

Name:						
Medicare number:						