Australian Government

COVID-19 VACCINATION

Ocean Wave Medical Covid Vaccine Clinic

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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.

Name:												
Medicare number:												

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?

Please talk to your doctor if you have any questions or concerns before getting your COVID-19 vaccination.

If new patient to Ocean Wave Medical, please bring Patient Health Summary or Care Plan for 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 number:	
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 emergency):	
Name:	
Phone contact number:	

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:	

☐ 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 signature:	
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

Dose 1:

Date vaccine administered:	
Time received:	
COVID-19 vaccine brand administered:	
Batch no:	
Serial no:	
Site of vaccine injection:	
Name of vaccination service provider:	

Dose 2

Date vaccine administered:	
Time received:	
COVID-19 vaccine brand administered:	
Batch no:	
Serial no:	
Site of vaccine injection:	
Name of vaccination service provider:	