McKinley Medical Centre

☐ 1st COVID
☐ 2nd COVID

433 Police Road
Mulgrave, VIC 3170
Ph (03) 9795 4011
Fax (03) 9795 2000
mckinleymc.com.au

AstraZeneca COVID Vaccine

Name: _____

Medicare: _____

Date of birth: _____

Address: _____

Phone contact number: _____

e-mail: _____

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). 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 have an Epi Pen or have had one before.
- 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, or carry or have been prescribed an adrenaline autoinjector (EpiPen)?
☐	☐	Have you had an allergic reaction after being vaccinated before?
☐	☐	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 (having a baby) or think you might be pregnant?
☐	☐	Are you planning to get pregnant?
☐	☐	Are you breastfeeding?
☐	☐	Do you have a cough, sore throat, fever or are feeling sick in another way?
☐	☐	Have you had a COVID-19 vaccination before? If so, where? _____
☐	☐	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.

☐ I confirm I have received & understood information provided to me on the COVID-19 vaccination

☐ I agree to receive a course of COVID-19 vaccine (two doses of the same vaccine).

Patient's Name:
Patient's D.O.B:
Patient's Signature:

_____

Date: