McKinley Medical Centre

☐1st Vaccine
☐2nd Vaccine
☐3rd Vaccine

433 Police Road
Mulgrave, VIC 3170
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Pfizer / Mederna Vaccine Consent

Name: ______________________________

Medicare: ______________________________

Date of birth: ______________________________

Address: ______________________________

Phone contact number: ______________________________

e-mail: ______________________________

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?
☐	☐	Have received any other vaccination in the last 14 days?
☐	☐	Have you ever had myocarditis or pericarditis?
☐	☐	Do you currently have or recently had acute rheumatic fever or endocarditis?
☐	☐	Do you have congenital heart disease?
☐	☐	For people under 30 years of age: do you have dilated cardiomyopathy?
☐	☐	Are you a recipient of a heart transplant?

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).

☐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 provider.

Patient's Name: ______________________ **Patient's D.O.B:** ______________________

Patient's Signature: ______________________ **Date:** ______________________