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Could you please assist us by completing the following:

Surname			Mr / Mrs / Miss / Ms / Dr (Please circle)
First Name			Date of Birth:
Street Address			
Suburb and Post Code			
Mobile Phone		Home Phone	
Email			
Medicare Number			Medicare
Medicare Patient Ref No:	1 2 3 4 5 6 7 (Please circle)	Expiry Date	
Next of Kin (Name and Phone)			

Do you have any allergies or are you sensitive to drugs or dressings:

Nil known ☐ Yes ☐ (If yes please list here)

Have you had an Influenza vaccination Yes / No / Unsure Date of vaccination/...../.....

Have you had a Covid Vaccination Yes / No / Unsure Date of vaccination/...../.....

Alcohol Questionnaire

1	How often do you have a drink containing alcohol?	2	How many drinks would you have on a typical day?
(a)	never	(a)	1-2
(b)	monthly or less	(b)	3-4
(c)	2-4 times per month	(c)	5-6
(d)	2-3 times per week	(d)	7 to 9
(e)	4 or more times per week	(e)	10 or more
3	How often would you have more than 6 standard drinks per day?		
(a)	never		
(b)	less than monthly		
(c)	monthly		
(d)	weekly		
(e)	daily or second daily		

Smoking Questionnaire

1	Do you smoke?	2	Have you smoked in the past?
(a)	yes	(a)	yes
(b)	no	(b)	no
If YES how many per day		If YES when did you give up?	

Ethnicity **Weight** **Height (cm)**

Consent form for COVID-19 vaccination - 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? |
| ☐ | ☐ | 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.

Patient information

Are you Aboriginal and/or Torres Strait Islander?

- | | |
|--|---|
| ☐ Yes, Aboriginal only | ☐ No |
| ☐ Yes, Torres Strait Islander only | ☐ Prefer not to answer |
| ☐ Yes Aboriginal and Torres Strait Islander | |

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:		DOB	
Patient's signature:		Date	

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

Legal guardian/substitute decision-maker's name:			
Legal guardian/substitute decision maker's signature		Date	