COWRA MEDICALASSOCIATES

165-169 Kendal Street
Cowra NSW 2794
Ph: 02 63411400 Fax: 02 63411410

Covid19 Vaccination Astra Zeneca Consent

Patient Surname:
Patient First Name:
Date of Birth:
Medicare Card / OR Passport Number:

Please answer the following and Sign at the bottom:

YES	NO	
☐	☐	Have you ever been diagnosed with capillary leak syndrome?
☐	☐	Have you ever had major venous and/or arterial thrombosis in combination with thrombocytopenia, including diagnosed Thrombotic Thrombocytopenic Syndrome (TTS), following a previous dose of a COVID-19 vaccine?
☐	☐	Have you ever had cerebral venous sinus thrombosis? *
☐	☐	Have you ever had heparin-induced thrombocytopenia? *
☐	☐	Have you ever had blood clots in the abdominal veins (splanchnic veins)? *
☐	☐	Have you ever had antiphospholipid syndrome associated with blood clots? *
☐	☐	Are you under 60 years of age?

☐	☐	Have you had any other vaccine in the past 7 days?
☐	☐	Have you had a previous Covid19 vaccine? If so what Brand? ……
☐	☐	Have you had an allergic reaction to a previous Covid19 Vaccine?
☐	☐	Have you ever had an anaphylaxis ore severe allergic reaction to anything?

I am making this decision voluntarily. I understand the benefits of vaccination/ that it is possible for me to still contract Covid19 despite being vaccinated/ I understand the potential outcomes and side effects. I feel that I have sufficient information to make an informed decision and consent to proceed with receiving the Covid19 Vaccine. I understand that this requires more than dose and/ or ongoing boosters.

Signature :

Date :