COWRA MEDICALASSOCIATES

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Cowra NSW 2794
Ph: 02 63411400 Fax: 02 63411410

Covid19 Vaccination Pfizer(Comirnaty) 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 had myocarditis or pericarditis?
☐	☐	Do you have congenital heart disease?
☐	☐	Do you have or recently had Acute Rheumatic fever or endocarditis?
☐	☐	Do you have severe heart failure?
☐	☐	Are you the recipient of a heart transplant?
☐	☐	If you are under 30 years do you have dilated cardiomyopathy?
☐	☐	Are you pregnant?

☐	☐	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 :