Warrandyte Road Clinic

Covid-19 Pfizer vaccination CONSENT FORM

About the Pfizer COVID-19 vaccination

People who have a COVID-19 vaccination have a much lower chance of getting sick from COVID-19.

You need to have the vaccination two times, ideally **3 weeks apart**.

Some people may still get COVID-19 after vaccination. So you must still follow public health precautions as required in Victoria to stop the spread of COVID-19.

On the day of your vaccine

Please wear short sleeves if possible.

Your doctor will not have sufficient time to address any other medical issues during your appointment.

What to expect after vaccination

Medical experts have studied COVID-19 vaccines to make sure they are safe. Most side effects are mild and go away within one or two days.

Common side effects (affecting about 50% of people who receive the vaccine) include:

- Pain, swelling or tenderness at the injection site
- Tiredness
- Headache
- Muscle pain
- Fever and chills
- Joint pain

Less common side effects include:

- redness at the injection site
- nausea
- enlarged lymph nodes
- feeling unwell
- pain in limb
- itching at the injection site.

If you experience pain at the injection site or fever, headaches or body aches after vaccination, you can take paracetamol or ibuprofen.

As with any vaccine, there may be rare or unknown side effects. **Very uncommon side effects** include:

- Severe allergic reaction (anaphylaxis): this occurs in 1 in a million people getting the vaccine.

You should seek medical attention if you think you are having an allergic reaction or if you have symptoms that persist more than a few days.

Please turn over ➔

Screening questions:

Yes	No	
☐	☐	Do you have any serious allergies, particular anaphylaxis to anything?
☐	☐	Have you had an allergic reaction after being vaccinated before?
☐	☐	Have you had COVID-19 before?
☐	☐	Are you sick with a cough, sore throat, or fever?
☐	☐	Have you had a COVID-19 vaccination before?
☐	☐	Have you received any other vaccination in the last 14 days?

Consent to receive the Pfizer COVID-19 vaccine:

☐ I confirm I have received and understood information provided to me on COVID-19 vaccinations.

☐ I agree to receive a course of COVID-19 vaccine (two doses of the same vaccine) 3 weeks apart.

Patient/guardian name:	
Patient DOB:	
Patient/guardian signature:	
Date:	

For clinic use:

Batch number:	Serial number:	Site given:	Provider: