**CONSENT FORM FOR COVID 19 VACCINATION**

ABOUT COVID-19 VACCINATION

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

You may choose whether to have the vaccination or not.

To be vaccinated you will get a needle in your arm. You need to have the vaccination two times on different days. There are different brands of vaccine. You need to have the same brand of vaccine both times. The person giving your vaccination will tell you when you need to have the second vaccination.

Most side effects are mild and don’t last for long. They may start on the day of vaccination and last for around 1-2 days. As with any vaccine or medicine, there may be rare and/or unknown side effects.

A possible rare side effect of blood clots in the brain or other body sites is currently being investigated. It is not known if this condition is caused by the vaccine – this is currently being investigated. This condition has been reported in the 4-20 days after vaccination with COVID-19 AstraZeneca vaccine at a rate of about 1 to 8 people for every one million people vaccinated.

You may be contacted by SMS within the week after receiving the vaccine to see how you are feeling after vaccination.

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

Vaccination providers record all vaccinations on the Australian Immunisation Register, as required by Australian law.

**Consent to receive COVID-19 vaccine**

* I confirm that I have received and understood information provided to me on COVID-19 vaccination.
* I confirm that none of the conditions in eligibility checker 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:-----------------------------------------------------Date of birth:------/-----------/---

Patient’s signature: --------------------------------------------------------------------------------------

Date:----/----/------