SARATOGA MEDICAL

COVID-19 Vaccination Consent form

SCREENING PRE-VACCINATION

YES / NO

- ☐ ☐ **Do you have any serious allergies, particularly anaphylaxis, to anything?**
- ☐ ☐ **Have you had an allergic reaction to a previous dose of a COVID-19 Vaccine?**
- ☐ ☐ **Have you had a serious adverse event, that following expert review was attributed to a previous dose of a COVID-19 Vaccine?**
- ☐ ☐ **Have you ever had mastocytosis which has caused recurrent anaphylaxis?**
- ☐ ☐ **Have you had an allergic reaction after being vaccinated before?**
- ☐ ☐ **Do you have a mast cell disorder?**
- ☐ ☐ **Have you had COVID-19 before?**
- ☐ ☐ **Do you have a bleeding disorder?**
- ☐ ☐ **Do you take any medication to thin your blood? (An anticoagulant therapy)?**
- ☐ ☐ **Do you have a weakened immune system? (Immunocompromised)?**
- ☐ ☐ **Are you pregnant or do you think you might be 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 you received any other vaccination in the last 14 days?**
- ☐ ☐ **Have you had cerebral venous sinus thrombosis (A type of brain clot) in the past?**
- ☐ ☐ **Have you had heparin-induced thrombocytopenia (A rare reaction to heparin treatment) in the past?**

Relevant only to those receiving AstraZeneca COVID-19 Vaccine

- ☐ ☐ **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 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?**

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Relevant only to those receiving Comirnaty

☐ ☐ **Have you ever had myocarditis or pericarditis?**

☐ ☐ **Do you currently have, or have you recently had acute rheumatic fever or endocarditis?**

☐ ☐ **Do you have congenital heart disease?**

☐ ☐ **For people under 30 years of age: do you have dilated cardiomyopathy?**

☐ ☐ **Do you have severe heart failure?**

☐ ☐ **Are you a recipient of a heart transplant?**

(If you have any concerns, please talk to your GP prior to receiving the vaccine)

CONSENT

☐ **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).**

Patients Name: _____DOB: _____

Signature: _____Date: _____

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

Guardian/Substitute Decision-Maker's Name:	
Guardian/Substitute Decision-Maker's Signature:	