



## Health Questionnaire (continued)

- Has your child received any other vaccination in the last 7 days?  Yes  No
- Has your child had an allergic reaction to a previous dose of a COVID-19 vaccine?  Yes  No
- Has your child had any other serious adverse reaction to a previous dose of COVID-19 vaccine?  Yes  No
- Has your child ever had anaphylaxis to another vaccine or medication?  Yes  No
- Has your child ever had mastocytosis (a mast cell disorder) which has caused recurrent anaphylaxis?  Yes  No
- Has your child had a bleeding disorder or are they currently taking any medicine to thin their blood (an anticoagulant therapy)?  Yes  No
- Does your child have a medical condition that causes severe immunocompromise? \*\*  Yes  No
- Has your child had a COVID-19 infection before?  Yes  No
- Has your child been sick recently with a cough, sore throat, fever or are feeling sick in another way?  Yes  No
- Is your child pregnant?  Yes  No

\*\*Individuals with a medical condition that causes severe immunocompromise, requesting a third dose will need to complete the [Eligibility Declaration form to show they are eligible for a third dose of a COVID-19 vaccine](#).

### Relevant for Pfizer or Moderna COVID-19 vaccine only

- Has your child been diagnosed with myocarditis and/or pericarditis that is attributed to a previous dose of Pfizer or Moderna?  Yes  No
- Has your child had myocarditis or pericarditis within the past 3 months?  Yes  No
- Does your child currently have acute rheumatic fever or acute rheumatic heart disease?  Yes  No
- Does your child have severe heart failure?  Yes  No

If you answered Yes to any of the above questions, you may still be able to receive Pfizer or Moderna, however you should talk to your GP, immunisation specialist or cardiologist first to discuss the best timing of vaccination and whether any additional precautions are needed.

- I confirm that none of the conditions above apply, or I have discussed these and/or any other special circumstances with my dependant's regular health care provider and/or vaccination service provide  Yes  No

## Consent to receive COVID-19 vaccine

- I confirm I have received and understood information provided to me on COVID-19 vaccination  Yes  No
- I have an existing VaccinateWA account  Yes  No if you do not have a VaccinateWA account, one will be created for you
- I agree to have my dependant's account linked to my VaccinateWA account  Yes  No
- I give my permission for WA Health to contact me by email, telephone or SMS to monitor vaccine safety and effectiveness  Yes  No
- I am the patient's legal guardian or legal substitute decision-maker, and agree to COVID-19 vaccination of the patient named above  Yes
- I agree to my dependant receiving a course of COVID-19 vaccines  Yes

Signature of legal guardian (*mandatory*)

### Legal guardian or legal substitute decision-maker details

Full name

Date of birth  /  /

Gender  Male  Female  Undisclosed  Non-binary

Relationship to dependant

### Do you identify as Aboriginal and/or Torres Strait Islander?

- No  Yes, Aboriginal  Yes, Torres Strait Islander  Both  Prefer not to say

Email address

Tick box to confirm that this is the email address that communications should be sent to

Contact number

Medicare number

(including individual reference number)

Tick if you don't have a medicare number

Residential address

Tick if address is the same as dependant's address listed above

Suburb

Postcode

Office use only – verbal consent

Verbal consent for vaccination was given  Yes  No

Date

Time

Signature of person taking consent

Consent person's name

Contact number

Relationship to dependant

Data entry  AIR  webPAS  WINVAC  MMEX

Office use only – vaccine administration

Place vaccine batch label here

Vaccine serial number:

Injection site

Left arm  Right arm  Other

Dose number and administration date

Dose 1 – Date received  /  /   Dose 2 – Date received  /  /

Dose 3\* OR  Booster – Date received  /  /

\*The Dose 3 option refers to individuals who are receiving a 3<sup>rd</sup> dose as part of a primary course of the COVID-19 vaccine.

Brand of vaccine

Comirnaty (Pfizer)  Vaxzevria (AstraZeneca)  Spikevax (Moderna)  Other

Signature of vaccinator

I hereby confirm that the details of the immunisation are correct. I acknowledge the integrity of this data and this may be integrated with other systems.

Name of vaccinator

HE or employee number

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