Government of **Western Australia**
Department of **Health**

COVID-19

WA Health COVID-19 Vaccination Consent Form – Students Aged 12 Years and Over

Only return this form if you agree to your child/dependant receiving the COVID-19 vaccination.

Before completing this form make sure you have read the information sheet on the COVID-19 vaccine you will be receiving.

Shade Circles Completely — Correct: ● Incorrect: ✓ ✗

Black Ink Only

Please print neatly in capital letters

EXAMPLE 123

Section 1: Student consent: provide information as completely as you can: all information will be kept confidential

First name

Last name

Date of birth (e.g. 05/08/1990) / /

Gender ○ Male ○ Female ○ Undisclosed ○ Non-binary

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

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

Telephone number (mobile preferred)

Email address

Medicare number (including individual reference number)

Residential address

Suburb Postcode

Next of kin (in case of emergency)

Name

Contact number

School information

Name of school

Year group

Section 2: Health Questionnaire

Has your child previously received the COVID-19 vaccine? ○ **Yes** ○ **No**

State Country

Previous doses received: Tick all that apply

Primary course: ○ Dose 1 ○ Dose 2 ○ Dose 3* – Immunocompromised only ○ Booster (16-18 years only)

Details of LAST dose

○ Comirnaty (Pfizer) ○ Spikevax (Moderna) ○ Nuvaxovid (Novavax) ○ Other

Date received / /

Health Questionnaire (continued)

Is your child pregnant?	○ Yes ○ No
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
If Yes, vaccine received? ○ Pfizer ○ Moderna ○ Novavax ○ Other	
Has your child had any other serious adverse reaction to a previous dose of COVID-19 vaccine?	○ Yes ○ No
If Yes, vaccine received? ○ Pfizer ○ Moderna ○ Novavax ○ Other	
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? If Yes, date of infection / /	○ Yes ○ No
Has your child been sick recently with a cough, sore throat, fever or are feeling sick in another way?	○ Yes ○ No
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 ever had cerebral venous sinus thrombosis (a type of brain clot)?*	○ Yes ○ No
Has your child ever had heparin-induced thrombocytopenia (a rare reaction to heparin treatment)?*	○ Yes ○ No
Has your child ever had blood clots in the abdominal veins (splanchnic veins)?*	○ Yes ○ No
Has your child ever had antiphospholipid syndrome associated with blood clots?*	○ Yes ○ No
Has your child had capillary leak syndrome in the past?*	○ Yes ○ No
Has your child had thrombosis (clotting) with thrombocytopenia (low platelets) syndrome after having a previous dose of AstraZeneca?*	○ 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
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

*Pfizer or Moderna are the preferred vaccines for people in these groups.

**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.

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.

Section 3: 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)* _____ Date / /

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

Clinic use only – verbal consent via phone

Verbal consent via phone ☐ **Yes** ☐ **No**

Complete legal guardian/legal substitute decision maker details in 'Section 3'.

Date and time of consent ☐☐/☐☐/☐☐☐☐ ☐☐:☐☐ hrs

Name of vaccinator taking consent _____ HE or employee number

Signature of vaccinator _____ Date ☐☐/☐☐/☐☐☐☐

Name of second vaccinator taking consent _____ HE or employee number

Signature of second vaccinator _____ Date ☐☐/☐☐/☐☐☐☐

Office use only – vaccine administration

Dose

Primary course: ☐ Dose 1 ☐ Dose 2 ☐ Dose 3* – Immunocompromised only ☐ Booster** (16-18 years only)

*The Dose 3 option refers to individuals who are receiving a 3rd dose as part of a primary course of the COVID-19 vaccine.
**The booster option refers to individuals who are receiving a booster dose following a 2-dose OR 3-dose primary course.

Date/time of administration ☐☐/☐☐/☐☐☐☐ ☐☐:☐☐ hrs

Brand of vaccine

☐ Comirnaty Tozinameran (Pfizer) ☐ Other _____

Place vaccine batch label here

Vaccine serial number:

Injection site

☐ Left arm ☐ Right arm ☐ Other

Signature of vaccinator _____ Date ☐☐/☐☐/☐☐☐☐

Name of vaccinator _____ HE or employee number

☐ 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.