



WA Health COVID-19 Vaccination Student Consent Form

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

E X A M P L E 1 2 3

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

Health Questionnaire

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

State Country

How many doses did your child receive?

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

What brand of vaccine did your child receive?

Pfizer-BioNTech Oxford-AstraZeneca Moderna Other

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
- 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
- Have your child been sick recently with a cough, sore throat, fever or are feeling sick in another way? Yes No

**Individuals with a medical condition that causes severe immunocompromise 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, pericarditis or endocarditis within the past six 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.

Consent to receive COVID-19 vaccine

- I confirm I have received and understood information provided to me on COVID-19 vaccination Yes No
- I agree to my dependant receiving a course of COVID-19 vaccine (two doses of the same vaccine) 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 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

Signature of person receiving vaccine

Legal guardian or legal substitute decision-maker details

- I am the patient's legal guardian or legal substitute decision-maker, and agree to COVID-19 vaccination of the patient named above Yes No

First name

Last name

Date / /

Email address

Contact number

Signature of legal guardian or legal substitute decision-maker

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 resident

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 – Date received / /

Brand of vaccine

Pfizer-BioNTech Oxford-AstraZeneca 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