

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?

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:	