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 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 medicine 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 received any other vaccination in the last 14 days?

Consent

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

☐ 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)

Patient's 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:	