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

**COVID-19**

# WA Health COVID-19 Vaccination Student Consent Form

**Only return this form if you agree to your 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** 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?**

○ Comirnaty (Pfizer) ○ Vaxzevria (AstraZeneca) ○ Spikevax (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, 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 vaccine (two doses of the same vaccine) ○ **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

**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 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* **OR** ○ Booster – Date received / /

*The Dose 3 option refers to individuals who are receiving a 3rd 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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