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

COVID-19

WA Health COVID-19 Vaccination Consent Form – Children Aged 6 months – 5 years

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
E X A M P L E 1 2 3

Section 1: 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

Does your child identify as Aboriginal or Torres Strait Islander?

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

Telephone number of parent/guardian (mobile preferred)

Email address of parent/guardian

Medicare number of child (including individual reference number)

Residential address of child

Suburb   Postcode

Next of kin (in case of emergency)

Name

Contact number

Section 2: Health Questionnaire

Has your child previously received a 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?

○ 6 months to 5 years SpikeVax Moderna (Blue Cap)   ○ Other

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? ○ 6 months to 5 years SpikeVax Moderna (Blue Cap)

Health Questionnaire (continued)

Has your child had any other serious adverse reaction to a previous dose of COVID-19 vaccine? ○ Yes ○ No

If Yes, vaccine received? ○ 6 months to 5 years SpikeVax Moderna (Blue Cap)

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 ever had a febrile convulsion? ○ 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 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 been diagnosed with myocarditis and/or pericarditis that is attributed to a previous dose of Comirnaty Tozinameran (Pfizer)? ○ 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 child/dependant's regular health care provider and/or vaccination service provider ○ 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 your child may still be able to receive Comirnaty Tozinameran (Pfizer), 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 child/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 child/dependant's legal guardian or legal substitute decision-maker, and agree to COVID-19 vaccination of the individual named above ○ Yes

I agree to my dependent receiving a dose of 6 months to 5 years SpikeVax Moderna (Blue Cap) ○ Yes

Signature of legal guardian/ legal substitute *(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 child/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

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

Date/time of administration ___ / ___ / ___ ___ : ___ hrs

Brand of vaccine

☐ 6 months to 5 years SpikeVax Moderna (Blue Cap) ☐ Other ____________________

Place vaccine batch label here

Vaccine serial number:

Injection site

☐ Left arm ☐ Right arm ☐ Left leg ☐ Right leg ☐ Other

Signature of vaccinator ____________________

Date ___ / ___ / ___

HE or employee number

Name 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.

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