

COVID-19 vaccine administration system downtime form



SMR130092

COVID-19 vaccination appointment details:

Appointment date	/ /	(Date / Month / Year)	Appointment time
Appointment location			

Demographics:

Given name <i>(as displayed on Medicare card)</i>		Middle initial	Family name
Sex:	Male	Female	Other Unknown
Date of birth	/ /	(Date / Month / Year)	
Indigenous status:	Aboriginal	Torres Strait Islander	Aboriginal & Torres Strait Islander Neither
Country of birth			

Contact details:

Residential address <i>(as recorded on Medicare)</i>	
Mobile number	
Email address	

Medicare details:

Residence status	Eligible Australian resident	Ineligible overseas resident
	Reciprocal overseas resident	Unknown
Medicare number	-	-
	Position on card (IRN)	Expiry date: /

Person to contact/Next of kin:

Full name	
Phone number	

Patient COVID-19 vaccination history:

Doses previously administered	First dose	Second dose	Third dose	Booster dose	Nil doses administered
COVID-19 vaccine first dose date administered: / / <i>(Day/Month/Year)</i>	Pfizer (Comirnaty) 12+	Moderna (Spikevax)	AstraZeneca (Vaxzevria)		
	Pfizer (Comirnaty) 5 to ≤12 years	Novavax (Nuvaxovid)	other _____		
COVID-19 vaccine second dose date administered: / / <i>(Day/Month/Year)</i>	Pfizer (Comirnaty) 12+	Moderna (Spikevax)	AstraZeneca (Vaxzevria)		
	Pfizer (Comirnaty) 5 to ≤12 years	Novavax (Nuvaxovid)	other _____		
COVID-19 vaccine third dose <i>(immunocompromised)</i> date administered: / / <i>(Day/Month/Year)</i>	Pfizer (Comirnaty) 12+	Moderna (Spikevax)	AstraZeneca (Vaxzevria)		
	Pfizer (Comirnaty) 5 to ≤12 years	Novavax (Nuvaxovid)	other _____		
COVID-19 vaccine booster dose date administered: / / <i>(Day/Month/Year)</i>	Pfizer (Comirnaty) 12+	Moderna (Spikevax)	AstraZeneca (Vaxzevria)		
	Pfizer (Comirnaty) 5 to ≤12 years	Novavax (Nuvaxovid)	other _____		

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Consent: <i>Tick your answer in the box on the right</i>	Yes	No
Have you been sick with a cough, sore throat, fever or are you feeling unwell today?		
Have you had a serious allergic reaction (anaphylaxis) to another vaccine or medication?		
Have you had a serious adverse event, that following expert review by an experienced immunisation provider or medical specialist was attributed to a previous dose of a COVID-19 vaccine (and did not have another cause identified)?		
Have you ever had mastocytosis (a mast cell disorder) which has caused recurrent anaphylaxis?		
Have you had COVID-19 (or SARS-CoV-2 infection) recently (within the last 3 months)? If YES : Have you completely recovered from your COVID-19 illness? Yes No If YES : Have you received COVID-19 treatment in the last 90 days using monoclonal antibody or convalescent plasma treatment? Treatment received: _____ Date of last treatment: / / (Day/Month/Year)		
Do you have a bleeding disorder or do you take any medicine to thin your blood (an anticoagulant therapy)?		
Do you have a weakened immune system (immunocompromised)?		
Are you pregnant? #		
Have you received any other vaccination in the last 7 days?		

Pfizer (Comirnaty) or Moderna (Spikevax) are the preferred vaccines for pregnant women. If these vaccines are not available, Novavax (Nuvaxovid) or AstraZeneca (Vaxzevria) can be considered.

Relevant only for those receiving Novavax (Nuvaxovid) and AstraZeneca (Vaxzevria): <i>Tick your answer in the box on the right</i>	Yes	No
Do you have any severe allergies, particularly anaphylaxis (to anything including Polysorbate 80)?		

Relevant only for those receiving AstraZeneca (Vaxzevria): <i>Tick your answer in the box on the right</i>	Yes	No
Have you ever been diagnosed with capillary leak syndrome?		
Have you ever had cerebral venous sinus thrombosis? *		
Have you had thrombosis (clotting) together with thrombocytopenia (low platelets) within 42 days after having a previous dose of AstraZeneca (Vaxzevria) COVID-19 vaccine?		
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? *		
Are you under 60 years of age? *		

* Pfizer (Comirnaty), Moderna (Spikevax) or Novavax (Nuvaxovid) are the preferred vaccines for people in these groups. If these vaccines are not available, AstraZeneca (Vaxzevria) can be considered if the benefits of vaccination outweigh the risks.

Relevant only for those receiving Pfizer (Comirnaty) or Moderna (Spikevax): <i>Tick your answer in the box on the right</i>	Yes	No
Do you have any severe allergies, particularly anaphylaxis (to anything including polyethylene glycol)?		
Have you been diagnosed with myocarditis and/or pericarditis that is attributed to a previous dose of Pfizer (Comirnaty) or Moderna (Spikevax) COVID-19 vaccines?		
Have you had myocarditis, pericarditis or endocarditis within the past three months?		
Do you currently have acute rheumatic fever or acute rheumatic heart disease?		
Do you have severe heart failure?		

If you answered **Yes** to any of the above questions, you may still be able to receive Pfizer (Comirnaty) or Moderna (Spikevax), 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.

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Declaration:

I have received the information provided to me in the Australian Government COVID-19 vaccination (select appropriate COVID-19 vaccine below)

[Information on Pfizer \(Comirnaty\) COVID-19 vaccine](#)

[Information on Pfizer \(Comirnaty\) 5 to ≤12 years COVID-19 vaccine](#)

[Information on Moderna \(Spikevax\) COVID-19 vaccine](#)

[Information on Novavax \(Nuvaxovid\) COVID-19 Vaccine](#)

[Information on AstraZeneca \(Vaxzevria\) COVID-19 Vaccine](#)

and have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions. Please refer to the Australian Government COVID-19 vaccination patient resources www.health.gov.au/resources/collections/covid-19-vaccination-patient-resources

I consent to receive a COVID-19 Vaccine

Patient's name			
Patient's signature	Print and Sign	Date:	/ / (Date/Month/Year)

I am the child's parent or guardian and agree to a COVID-19 vaccination of the patient named above. I understand the nature of the treatment and that undergoing the treatment carries risks. I understand that I may withdraw my consent.

Note: Substitute Consent under the Guardianship Act 1987 requires completion of the Substitute Consent for Medical Procedure / Treatment Consent Form.

Parent/Guardian name			Relationship to child	
Parent/Guardian signature	Print and Sign	Date:	/ / (Date/Month/Year)	

Use and Disclosure of Information

Information collected as part of this process will be subject to the same use and disclosure rules as other health information collected by the NSW Public Health System. Please refer to the NSW Health Privacy Leaflet for Patients <https://www.health.nsw.gov.au/patients/privacy/Pages/privacy-leaflet-for-patients.aspx>. Your personal and health information may be used and disclosed for purposes connected with the roll-out of the COVID-19 vaccine program, including sharing your information with the Australian Government and for surveillance, assessment and monitoring of the COVID-19 vaccine or vaccination program. Your personal information held in NSW Health's database such as name, phone number and email address may be used to contact you following your vaccination for monitoring purposes. You may receive an SMS message or an email in the days following your vaccination and further direct follow-up by NSW Health staff. If you are being offered vaccination on the basis of the type of work that you do, your employer may be contacted about your vaccination dates so that they can appropriately schedule staff at the workplace.

PROVIDER USE ONLY

Medication administration

Vaccination administration details				
COVID-19 vaccine brand name	Pfizer (Comirnaty) 12+	Moderna (Spikevax)	AstraZeneca (Vaxzevria)	
	Pfizer (Comirnaty) 5 to ≤12 years	Novavax (Nuvaxovid)		
Dose administered	First dose	Second dose	Third dose	Booster dose Dosage in mL: _____
Product label	Vial supply lot: _____		Vial serial number: _____	
	Vaccine expiry date: / /		(Date/Month/Year)	
Injection site:	Right arm	Left arm	Other	Observation time: 15 minutes 30 minutes
Date administered:	/ /	(Date/Month/Year)		Time administered:
Name				
Designation				
Signature	Print and Sign	Date:	/ / (Date/Month/Year)	Time:

Note: Adverse reaction Adverse event information must be recorded in the electronic medical record or paper Adverse Event Following Immunisation (AEFI) form.