

Name:

DOB:

Consent Checklist – Pfizer vaccine

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had an allergic reaction to a previous dose of a COVID-19 vaccine? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had anaphylaxis to another vaccine or medication? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a serious adverse event, that following expert review was attributed to a previous dose of a COVID-19 vaccine? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had mastocytosis, which has caused recurrent anaphylaxis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had COVID-19 before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a bleeding disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take any medicine to thin your blood (an anticoagulant therapy)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a weakened immune system (immunocompromised)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?* |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been sick with a cough, sore throat, fever or are feeling sick in another way? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a COVID-19 vaccination before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you received any other vaccination in the last 7 days? |

Relevant only for those receiving Comirnaty (Pfizer)

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|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had myocarditis or pericarditis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you currently have, or have you recently had acute rheumatic fever or endocarditis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have congenital heart disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | For people under 30 years of age: do you have dilated cardiomyopathy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have severe heart failure? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a recipient of a heart transplant? |