COVID-19 Vaccination Administration

Medicare number: 
Family name: 
Given name(s): 
Address: 
Date of birth: Age: Sex: 

Facility:__________________________________________

Health professional attestation statement
[ ] I have reviewed all allergies, precautions, potential contraindications and other pertinent health information regarding the COVID-19 vaccination and have formed the view it is clinically appropriate for the vaccinee to receive the COVID-19 vaccination.

[ ] I have formed the opinion that the young person or person to be vaccinated/substitute decision-maker/parent/legal guardian/other person:
• has the capacity to consent to receive the COVID-19 vaccination; OR
• is authorised to consent for the person to receive the COVID-19 vaccination and has the capacity to give this consent (if applicable)
• has understood the information in the "Queensland COVID-19 Vaccination Information" resource including the risks associated with having the COVID-19 vaccination
• has been provided with the opportunity to ask me or another health professional any questions relevant to the COVID-19 vaccination
• gives consent to receive the recommended doses of the COVID-19 vaccine.

Name of clinician:______________________________

Vaccination details

Date of vaccination*: __________________________
Time of vaccination (24hr): __________________________

Site of vaccination: [ ] (R) Deltoid [ ] (L) Deltoid [ ] (R) Thigh [ ] (L) Thigh [ ] Other (specify): __________________________

Brand of vaccination*: [ ] Pfizer Comirnaty [ ] AstraZeneca

Batch number*: __________________________
Expiration date: __________________________
Dose number*: [ ] 1st [ ] 2nd [ ] Other (specify): __________________________

Name of vaccinator:______________________________

Post-vaccination monitoring

Discharge time (24hr): __________________________
Condition on discharge: __________________________

Did an adverse event following immunisation (AEFI) occur prior to discharge? [ ] Yes [ ] No
If yes – complete an AEFI form within 12 hours of adverse event.

Name of monitoring clinician:______________________________

Additional comments

______________________________

[ ] Entered into QCVMS Vaccination Episode Spreadsheet

*Formal arrangements, such as parenting/custody orders, adoption, or other formally recognised carer/guardianship arrangements. Refer to the Queensland Health "Guide to Informed Decision-making in Health Care" and local policy and procedures. Complete the source of decision-making authority as applicable below.