COVID-19 Vaccination Patient Form

Title _____ First Name: _____ Surname: _____

Date of Birth: _____ Age: _____

Address: _____

Suburb: _____ Post code: _____

Home Tel: _____ Work Tel: _____ Mobile Tel: _____

Medicare Number (or IHI) _____ Ref [i.e. number next to your name] ____ Expiry date _____

Email: _____

Emergency contact name: _____Relation: _____

Emergency Contact phone number: _____

In the **last 6 months**, have you had COVID-19 infection or a COVID-19 Vaccination?

NO ☐ COVID-19 Infection: ☐ COVID-19 Vaccination: ☐

Are you of Aboriginal and/or Torres Strait Islander origin**?** □ **No** □ **Aboriginal** □ **Torres Strait Islander** □ **Both**

Country of Birth: _____ Native Language: _____

Do you suffer from any allergies? NO ☐ YES: ☐

If **YES**, please list your allergies: _____

MEDICATIONS: please list your current medications here:

_____ _____

_____ _____

_____ _____

_____ _____

PRIVACY:
Premier Medicine use a computerised medical record system. We take all precautions necessary with our computer system security and when emails or SMS correspondence are sent. NB: In the unlikely event of a security breach, your electronic information could be compromised.

This practice sends out SMS and/or emails for recalls, reminders, correspondence, and copies of results/reports. Do we have your permission to use these forms of communication for correspondence: □ **Yes** □ **No**

Please note: should you wish to attend our practice at a later date, for non-COVID19 vaccination related services, you will be provided a full list of our fees and charges, which are also available on request.

Patient signature _____ Date _____

If the Patient is under 18 years old:

Parent/Guardian signature _____ Date _____