COVID-19

VACCINE MEDICAL CONTRAINDICATION

Tasmanian Government

To whom it may concern,

I am a registered medical practitioner. I certify that,

Given name: _____ Family name: _____

DOB: ☐☐ / ☐☐ / ☐☐☐☐ Sex: ☐ Male ☐ Female ☐ Prefer not to say

Residential address: _____

_____

SECTION A – MEDICAL CONTRAINDICATION

☐ Has a history of anaphylaxis to any component of recommended COVID-19 vaccines and a suitable alternative COVID-19 vaccine is not available.

OR

SECTION B – TEMPORARY MEDICAL EXEMPTION

Has the following medical condition(s) and is exempt from receiving COVID-19 vaccination until:

☐☐ / ☐☐ / ☐☐☐☐

☐ Acute major illness, being:

_____

☐ Significant immunocompromise of short duration, being:

_____

☐ Other medical condition requiring temporary vaccine exemption, being:

_____

☐ Has had a severe adverse event attributed to a previous dose of COVID-19 vaccine, and is awaiting assessment by the Tasmanian Specialist Immunisation and Allergy Clinic.

☐ Confirmed SARS-CoV-2 infection in the past 6 months. Date of infection: ☐☐ / ☐☐ / ☐☐☐☐

Medical practitioner details

Name: _____ Telephone: _____

Address: _____

Email: _____ Registration No.: MED0000☐☐☐☐☐☐

Signature: _____ Date: ☐☐ / ☐☐ / ☐☐☐☐

Print and sign