

THORNLEIGH MARKET PLACE

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**COVID-19 ASTRAZENECA**

**WAIVER FORM**

This is to confirm that I have read and understood the information provided to me from the health care provider regarding COVID-19 AstraZeneca vaccination and its associated risks for people under 60 years of age.

I consent and agree to receiving a course of COVID-19 AstraZeneca vaccine (two doses of the same vaccine).

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_