Immunisation consent form

CITY OF HOLDFAST BAY

Please fill in details of person being vaccinated, as per Medicare card

Surname:	**First name:**	**Middle initial:**
Address:		
Email:	**Birth Gender: Male** ☐ **Female** ☐	
Mobile no:	**Aboriginal/Torres Strait Islander: Yes** ☐ **No** ☐	
Date of Birth:	**Age:**	**Medicare no:** ☐☐☐☐☐☐☐☐☐☐
HIGH SCHOOL STUDENTS ONLY **School:** **Year level:**		**Ref #** ☐

Vaccine(s) requested: (please tick)	
☐ **6 weeks**	DTPa/IPV/Hib/HepB, 13vPCV, RV, MenB
☐ **4 months**	DTPa/IPV/Hib/HepB, 13vPCV, RV, MenB
☐ **6 months**	DTPa/IPV/Hib/HepB
☐ **12 months**	MMR, MenACWY, 13vPCV, MenB
☐ **18 months**	MMRV, DTPa, Hib
☐ **4 years**	DTPa/IPV
☐ **Year 7**	HPV (Gardasil) ☐ dTpa (Adacel/Boostrix) ☐
☐ **Year 10**	Men ACWY (MenQuadfi) ☐ Men B (Bexsero) ☐ **Dose 1** ☐ **Dose 2** ☐ or ≥ 14yrs booster dose ☐ or ≥ 14yrs booster dose ☐
☐ **Pregnancy**	dTpa ☐ RSV ☐ Flu ☐
☐ **65 years +**	Shingles ☐ **Dose 1** ☐ **Dose 2** ☐ Flu ☐
☐ **Other funded vaccination** including catch-up vaccinations	
☐ **Paid vaccination**	Vaccine(s) requested: **Fee** ☐ **$** _____ **OR Worksite** ☐
☐ **Flu**	< 9yrs of age only **Dose 1** ☐ **Dose 2** ☐ **OR Dose 2 not required** ☐ — **Fee** ☐ **$** _____ **OR Funded** ☐ **OR Worksite** ☐

Office use only:	Date:	Time:
☐ LA ☐ RA ☐ LL ☐ RL ☐ ID ☐ IM ☐ SC ☐ O Dose# A C Other	☐ LA ☐ RA ☐ LL ☐ RL ☐ ID ☐ IM ☐ SC ☐ O Dose# A C Other	☐ LA ☐ RA ☐ LL ☐ RL ☐ ID ☐ IM ☐ SC ☐ O Dose# A C Other
Batch#	Batch#	Batch#

☐ LA ☐ RA ☐ LL ☐ RL ☐ ID ☐ IM ☐ SC ☐ O Dose# A C Other
Batch#

Pre-vaccination checklist:

Are you well today?

Yes ☐ No ☐

Comments:

For children ≤ 5yrs old:

Has birth dose of Hep B been given? Yes ☐ No ☐

Was born pre-term? Yes ☐ @_____weeks No ☐

For women:

Are you currently pregnant? Yes ☐ Gestation _____ weeks No ☐

Have you ever had a severe reaction after having any vaccine?

Yes ☐ No ☐

Do you have an ALLERGY or have you ever had a reaction to ANY medicine or food?

Yes ☐ No ☐

Do you have a bleeding disorder or other chronic medical condition?

Yes ☐ No ☐

Are you taking any medications? E.g. blood thinning medication, antibiotics

Yes ☐ No ☐

Have you had any vaccine or injection recently?

Yes ☐ No ☐

Have you received immunoglobulin or had a blood transfusion within the past 12 months?

Yes ☐ No ☐

Are you living with someone who has a disease which lowers immunity?

Yes ☐ No ☐

Have you ever fainted or felt dizzy after having an injection?

Yes ☐ No ☐

For people having flu vaccine:

Have you ever had Guillain-Barre Syndrome? Yes ☐ No ☐

CONSENT FOR VACCINATION: I have read and understood the information given to me about immunisation including the risks and benefits. I have been given the opportunity to discuss this with my Nurse. I consent for the above named to be vaccinated with the vaccines ticked above. I understand the information I provide, and information related to any vaccines administered, will be recorded electronically and/or in hard copy. I consent to the disclosure of this information to staff involved in the provision of an immunisation service for SA Health and local government councils (and their immunisation service providers) and to the Australian Immunisation Register, where it will be stored on the client's Medicare Account. I can contact my immunisation service provider if I am concerned personal information has been misused or subject to unauthorised access.

Client / Legal Guardian name (print):

Client / Legal Guardian signature:

Date

Nurse signature:

Date