CONSENT FOR IMMUNISATION

CHILD *(0 – 15 years)*

CITY OF TEA TREE GULLY *Naturally Better*

Medicare Number ☐☐☐☐☐☐☐☐☐☐ **Child's Reference Number** ☐

Child's Family Name: _____ Child's First Name: _____

Child's Middle Initial: _____ Date of Birth: ____/____/____ Age: _____ ☐ MALE ☐ FEMALE

Address: _____

_____ Postcode: _____

Telephone: _____ Email: _____

Please circle if the above child is Aboriginal Torres Strait Islander

Please tick ☑ vaccines required today		***Office Use only***	
6 weeks &	☐ Pneumococcal	.....	LL RL LA RA
4 months	☐ DTPa/IPV/HiB/Hep B	.....	LL RL LA RA
	☐ Rotavirus	.....	Oral only
	☐ Meningococcal B	.....	LL RL LA RA
6 months	☐ DTPa/IPV/HiB/Hep B	.....	LL RL LA RA
12 months	☐ Measles/Mumps/Rubella	.....	LL RL LA RA
	☐ Pneumococcal	.....	LL RL LA RA
	☐ Meningococcal ACWY	.....	LL RL LA RA
	☐ Meningococcal B	.....	LL RL LA RA
18 months	☐ Chickenpox + Measles/Mumps/Rubella	.....	LL RL LA RA
	☐ Diphtheria, Tetanus, Pertussis	.....	LL RL LA RA
	☐ Haemophilus influenzae type b	.....	LL RL LA RA
4 years	☐ Diphtheria, Tetanus, Pertussis / Inactivated Polio	.....	LL RL LA RA
Influenza	☐ Dose ……	.....	LL RL LA RA
Meningococcal B	☐ Dose ……	.....	LL RL LA RA
Other (specify)	☐	.....	LL RL LA RA

Additional vaccines for Aboriginal or Torres Strait Islander Children

6 months	☐ Pneumococcal	.....	LL RL LA RA
12 & 18 months	☐ Hepatitis A	.....	LL RL LA RA

PRE-VACCINATION CHECKLIST

This checklist provides important information about vaccinating your child (0 – 15 years of age) today.

Please circle Yes or No to indicate if the child to be vaccinated:

- is unwell today ..... Yes / No
- has a disease that lowers immunity (e.g. leukaemia, cancer, HIV/Aids)..... Yes / No
- is having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy)..... Yes / No
- lives with someone who has a disease or is having treatment that lowers immunity ..... Yes / No
- has had a severe reaction following any vaccine ..... Yes / No
- has any severe allergies to anything (please specify)..... Yes / No
- has had any vaccine in the past month ..... Yes / No
- has had an injection of immunoglobulin, or received any blood products or a whole blood transfusion within the past year ..... Yes / No
- has a past history of Guillain-Barré syndrome ..... Yes / No
- has a chronic illness ..... Yes / No
- has a bleeding disorder ..... Yes / No
- has a non-functioning or missing spleen ..... Yes / No
- is an infant of a mother who was receiving highly immunosuppressive therapy (e.g. biological disease modifying anti-rheumatic drugs (bDMARDs) during pregnancy ..... Yes / No
- was a preterm infant (less than 32 weeks) or low birth weight (less than 2000gms)..... Yes / No
- is pregnant or planning a pregnancy ..... Yes / No
- is planning travel..... Yes / No
- has an occupation or lifestyle factor(s) for which vaccination may be needed ..... Yes / No

Please specify: .....

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 the nurse. I consent for the named person to be vaccinated with the vaccines indicated. 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 SA Health and local government councils (and their immunisation service providers) and to the Australian Immunisation Register. I can contact my immunisation service provider if I am concerned personal information has been misused or subject to unauthorised access. If the issue remains unresolved, contact SA Health on 1300 232 272.

Name of PARENT or GUARDIAN_____

Signature _____ Relationship to child _____

Name of Nurse _____ Date _____

Signature of Nurse _____ Time_____

PLEASE NOTE: Parent or legal guardian MUST complete and sign consent form.