CONSENT FOR IMMUNISATION

HIGH SCHOOL IMMUNISATION CONSENT

Medicare Number ☐☐☐☐☐☐☐☐☐ ☐ **Reference Number** ☐

Family Name: ______________________________ First Name:___________________________

Middle Initial: __________ Date of Birth: ____/____/_____ Age: ______ ☐ MALE ☐ FEMALE

Address: ____

____ Postcode:____________

Telephone: _______________________ Email: ______________________________________

Name of School: ____ **Current Year Level**: ______

Please circle if Aboriginal Torrres Strait Islander

Please tick ☑ vaccines required today ***Office Use only***

Year 8	☐ Human Papillomavirus	Dose ……….	…………………………	LA	RA
	☐ Diphtheria, Tetanus, Pertussis	Dose ……….	…………………………	LA	RA
Year 10	☐ Meningococcal B	Dose ………	…………………………………	LA	RA
	☐ Meningococcal ACWY	Dose ……….	…………………………………	LA	RA
Other	☐ …………………………………	Dose ……….	…………………………………	LA	RA
Other	☐ …………………………………	Dose ……….	…………………………………	LA	RA

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.

CONSENT TO VACCINATE

(Student may consent if 16 years of age or over)

Relationship to Student ☐ Parent ☐ Legal Guardian ☐ I am the student

Signature of Student/Parent/Guardian ____

Full name of Parent/Guardian____

Name of Nurse ______________________________________ Date ___________________

Signature of Nurse ___________________________________ Time___________________

PLEASE TURN OVER TO COMPLETE PRE-VACCINATION CHECKLIST

PRE-VACCINATION CHECKLIST

This checklist provides important information about the person being vaccinated today.

Please circle Yes or No to indicate if the person 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: ....