CONSENT FOR IMMUNISATION - ADULT

(16 years and above)

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

Family Name: _____ First name: _____ 2nd Initial:_____

Maiden Name: _____ Date of Birth: ____/____/_____ Age: _____

Address: _____

_____ Postcode: _____ ☐ MALE ☐ FEMALE

Telephone:_____ Email: _____

Please circle if you identify as Aboriginal Torres Strait Islander

Do you require a receipt to claim from private health insurance? ☐ YES ☐ NO

Reason for vaccination? (eg work, pregnancy, new baby) _____

COVID-19 VACCINE DECLARATION:

Have you received a COVID-19 vaccine in the last 7 days? ☐ YES ☐ NO

If you answered "Yes" to the above, you must not have any other vaccine until the minimum 7 day period has lapsed since receiving the COVID-19 vaccine.

Please tick ☑ vaccines required today		**Batch**	**Office Use Only**
☐	Diphtheria, Tetanus, Pertussis (dTpa)	.....	LA RA
☐	Combined Hepatitis A & B	.....	LA RA
☐	Hepatitis A	.....	LA RA
☐	Hepatitis B	.....	LA RA
☐	Human Papillomavirus (HPV)	.....	LA RA
☐	Measles, Mumps & Rubella (MMR)	.....	LA RA
☐	Meningococcal B	.....	LA RA
☐	Meningococcal ACWY	.....	LA RA
☐	Varicella (Chickenpox)	.....	LA RA

I have been given the opportunity to discuss immunisation, including the risks and benefits, with a nurse. I consent to be vaccinated with the vaccines indicated. I understand the information I provide during the consent process, and information related to any vaccines administered, will be stored electronically and/or in hard copy as a medical record. 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 providers. I acknowledge that the immunisation record will be recorded on the Australian Immunisation Register where it will be stored on my Medicare account.

CONSENT TO VACCINATE

Signature _____ Date _____

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 vaccinating you today.

Please circle Yes or No to indicate if you:

- are unwell today..... Yes / No
- have a disease that lowers immunity (e.g. leukaemia, cancer, HIV/AIDS) ..... Yes / No
- are having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy) ..... Yes / No
- live with someone who has a disease or is having treatment that lowers immunity..... Yes / No
- have had a severe reaction following any vaccine ..... Yes / No
- have any severe allergies (to anything) ..... Yes / No
- have had any vaccine in the past month..... Yes / No
- have had an injection of immunoglobulin, or received any blood products or a whole blood transfusion within the past year ..... Yes / No
- are pregnant or are anticipating parenthood..... Yes / No
- have a past history of Guillain-Barré syndrome ..... Yes / No
- have a chronic illness..... Yes / No
- have a bleeding disorder..... Yes / No
- have a non-functioning or missing spleen..... Yes / No
- are a parent, grandparent or carer of a newborn ..... Yes / No
- are planning travel ..... Yes / No
- have an occupation or lifestyle factor(s) for which vaccination may be needed ..... Yes / No (discuss with nurse)

Please specify occupation/lifestyle factor: .....