CONSENT FOR IMMUNISATION

CHILD *(0 – 15 years)*

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
Other (specify)	☐	....	LL RL LA RA

Additional vaccines for Aboriginal or Torres Strait Islander Children

6 months	☐ Pneumococcal (13vPPV)	....	LL RL LA RA
18 months	☐ Hepatitis A	....	LL RL LA RA
4 years	☐ Hepatitis A	....	LL RL LA RA
	☐ Pneumococcal (23vPPV)	....	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 been given the opportunity to discuss immunisation, including the risks and benefits, with a nurse. I consent for the named person 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 child's Medicare account.

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.