

(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**

## Batch

**Office Use Only**

6 weeks &	<input type="checkbox"/> Pneumococcal	.....	LL	RL	LA	RA
4 months	<input type="checkbox"/> DTPa/IPV/HiB/Hep B	.....	LL	RL	LA	RA
	<input type="checkbox"/> Rotavirus	.....	Oral only			
	<input type="checkbox"/> Meningococcal B	.....	LL	RL	LA	RA
6 months	<input type="checkbox"/> DTPa/IPV/HiB/Hep B	.....	LL	RL	LA	RA
12 months	<input type="checkbox"/> Measles/Mumps/Rubella	.....	LL	RL	LA	RA
	<input type="checkbox"/> Pneumococcal	.....	LL	RL	LA	RA
	<input type="checkbox"/> Meningococcal ACWY	.....	LL	RL	LA	RA
	<input type="checkbox"/> Meningococcal B	.....	LL	RL	LA	RA
18 months	<input type="checkbox"/> Chickenpox + Measles/Mumps/Rubella	.....	LL	RL	LA	RA
	<input type="checkbox"/> Diphtheria, Tetanus, Pertussis	.....	LL	RL	LA	RA
	<input type="checkbox"/> Haemophilus influenzae type b	.....	LL	RL	LA	RA
4 years	<input type="checkbox"/> Diphtheria, Tetanus, Pertussis / Inactivated Polio	.....	LL	RL	LA	RA
Influenza	<input type="checkbox"/> Dose .....	.....	LL	RL	LA	RA
Other	<input type="checkbox"/> .....	.....	LL	RL	LA	RA
	<input type="checkbox"/> .....	.....	LL	RL	LA	RA

### Additional vaccines for Aboriginal or Torres Strait Islander Children

6 months	<input type="checkbox"/> Pneumococcal (13vPPV)	.....	LL	RL	LA	RA
18 months	<input type="checkbox"/> Hepatitis A	.....	LL	RL	LA	RA
4 years	<input type="checkbox"/> Hepatitis A	.....	LL	RL	LA	RA
	<input type="checkbox"/> 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 well 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, DMARDs (disease-modifying anti-rheumatic drugs, radiotherapy, chemotherapy) ..... Yes / No
- is an infant of a mother who was receiving highly immunosuppressive therapy (e.g. bDMARDs (biologic disease-modifying anti-rheumatic drugs) during pregnancy ..... Yes / No
- has had a severe reaction following any vaccine ..... Yes / No
- has any severe allergies to anything ..... Yes / No  
Please specify allergy: .....
- 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
- was a preterm infant (less than 32 weeks) or low birth weight (less than 2000gms)..... Yes / No
- has a severe or chronic illness ..... Yes / No
- has a bleeding disorder ..... Yes / No
- has a non-functioning or missing spleen ..... Yes / No
- is pregnant ..... Yes / No
- lives with someone who has a disease that lowers immunity (e.g. leukaemia, cancer, HIV/Aids) ..... Yes / No
- lives with someone who is having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, DMARDs, radiotherapy)..... Yes / No

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.**