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 the above person is: Aboriginal Torrres Strait Islander

Please tick ☑ vaccines required today				**Batch**	**Office Use Only**
Year 7 or 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

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 Medicare account.

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 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
- 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
- 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 prenisone, DMARDs, radiotherapy..... Yes / No