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www.eha.sa.gov.au ABN 52 535 526 438

Immunisation Consent
Child under 10 years old

Postcode: _____ Council area: _____

Family Name: _____ (As per Medicare card)

Email address:

Medicare No

First Name:

Client number:	
Postcode:	
Council:	
Number of Vaccines:	
School or workplace absentee	
Fee or Non-EHA Client or non medicare:	\$

Office Use Only:

_____ Middle Initial_____

Phone/mobile number: _____

PLEASE PRINT CLEARLY USING BLOCK LETTERS (FOR PERSON BEING IMMUNISED)

	If no Medicare Card, then fee payment is required before vaccination			
Pre	-Vaccination Checklist - Please read and tick the checklist below			
•	Is unwell today	□ Yes	□ No	
•	Has had a severe reaction following any vaccine	□ Yes	□ No	
•	Has had <u>any</u> vaccine in the past month	□ Yes	□ No	
•	Has a severe allergy to anything	□ Yes	□ No	
•	Has a history of Guillian-Barre syndrome (progressive paralysis)	□ Yes	□ No	
•	Has had an injection of immunoglobulin, or received any blood products or whole blood transfusions within the past year	□ Yes	□ No	
•	Do you have a chronic medical condition eg. diabetes or have a disease which lowers immunity (e.g. oral steroid medicines; cortisone and prednisolone, is undergoing radiotherapy, chemotherapy) Please specify:	□ Yes	□ No	
•	Do you have a functioning Spleen?	□ Yes	□ No	
•	Lives with someone who has a disease which lowers immunity (e.g. Leukaemia, cancer, HIV/AIDS), or lives with someone who is having treatment which lowers immunity (e.g. Oral steroid medicine such as cortisone and prednisone, radiotherapy, chemotherapy)	□ Yes	□ No	
•	INFLUENZA VACCINE ONLY – Are you taking the following medications? Warfarin, Theophylline, Phenytoin, Aminopyrine	□ Yes	□ No	
	Please turn over			

Date of birth: _____/___ Age: ___ □ Male □ Female □ Aboriginal &/or Torres Strait Islander

Address: ______ Suburb: _____

D18/10546

Ref No

YES - I have read, completed, and understood the Pre-vaccination checklist. I have been offered the information on the immunisations to read and will be given the opportunity to discuss the risks and benefits with an immunisation provider at the time of vaccination. I consent for the above named to be vaccinated with the vaccines ticked below. 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.

Name of person giving consent:	Signature:
Relationship to person being vaccinated:	Date:

<u>Note</u>: Please ask the nurse for information on any other matter relating to vaccination before vaccines are given.

Parent please tick below which vaccines are required today			*Below is office use only*		
Tick	Age	Vaccine	Batch No.	Site	Dose
	6 weeks	Infanrix Hexa – Haemophilus Influenzae Type B/ Hepatitis B/ Diphtheria/ Tetanus/ Pertussis/ Inactivated Poliomyelitis			
		Prevenar 13 — Conjugate Pneumococcal 13 valent			
		Rotarix – Oral Rotavirus vaccine			
		Bexsero – Meningococcal B			
		Infanrix Hexa – Haemophilus Influenzae Type B/ Hepatitis B/ Diphtheria/ Tetanus/ Pertussis/ Inactivated Poliomyelitis			
	4 months	Prevenar 13 — Conjugate Pneumococcal 13 valent			
	4 months	Rotarix – Oral Rotavirus vaccine			
		Bexsero – Meningococcal B			
	6 months	Infanrix Hexa – Haemophilus Influenzae Type B/Hepatitis B/ Diphtheria/ Tetanus/ Pertussis/ Inactivated Poliomyelitis			
	Aboriginal* or MAR*	Prevenar 13 – Conjugate Pneumococcal 13 valent			
		Priorix or MMR II – Measles/Mumps/Rubella			
	12 months	Prevenar 13 – Conjugate Pneumococcal 13 valent			
		Nimenrix – Meningococcal Conjugate ACWY			
		Bexsero – Meningococcal B			
	MAR*	HB VAX II or Engerix B – Hepatitis B paediatric			
	18 months	Priorix-Tetra or Pro Quad – Measles/Mumps/Rubella/Varicella			
		Infanrix or Tripacel – Diphtheria/ Tetanus/ Pertussis			
		Act-HIB – Haemophilus Influenzae Type B			
	18 months Aboriginal*	Vaqta – Hepatitis A			
	4 years	Infanrix IPV or Quadracel – Diphtheria/ Tetanus/ Pertussis/ Inactivated Poliomyelitis			
	MAR*	Pneumovax 23 – Polysaccharide Pneumococcal 23 valent			
	4 years Aboriginal*	Pneumovax 23 – Polysaccharide Pneumococcal 23 valent Vaqta – Hepatitis A			
	Other	Bexsero – Meningococcal B			
	Other	Influenza			
	Other				

Immunisation provid	ler name:	Signature:	
Date:	Time:	Comments:	

Aboriginal* - inclusive of Aboriginal and Torres Strait Islander People

MAR* – Medically At-Risk