EASTERN HEALTH AUTHORITY

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St Peters SA 5069

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Stepney SA 5069

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eha@eha.sa.gov.au

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

Office Use Only:

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

Immunisation Consent

Adolescent/Adult

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

Family Name: ____

(As per Medicare card)

First Name: ________________________________ Middle Initial________________

Date of birth: ______/_____/_____ Age: _____ ☐ Male ☐ Female ☐ Aboriginal &/or Torres Strait Islander

Address: ______________________________________ Suburb:______________________

Postcode: __________ Council area:_____________________Phone/mobile number: ________________________

School attending (if applicable)____

Email address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Medicare No ☐☐☐☐ ☐☐☐☐☐ ☐ Ref No ☐

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 **any** vaccine in the past month	☐ Yes ☐ No
• Has a severe allergy to anything	☐ Yes ☐ No
• Is pregnant	☐ 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
• Is a parent, grandparent or carer of a newborn	☐ 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

***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 (if not self): ________________________

Date: ________________________

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

Please tick below which vaccines required ***Below is office use only***

Tick	Vaccine	Batch No.	Site	Dose
☐	**Boostrix/Adacel** – Diphtheria, Tetanus and Pertussis (Whooping cough)			
☐	**Gardasil –** Human Papillomavirus			
☐	**Varilrix/Varivax** – Varicella (Chicken Pox)			
☐	**Bexsero** – Meningococcal B			
☐	**Priorix or MMR II –** Measles/Mumps/Rubella			
☐	**Nimenrix –** Meningococcal ACWY			
☐	**Neisvac –** Meningococcal C			
☐	**Prevenar 13 –** Pneumococcal – ≥ 70 years			
☐	**Pneumovax 23** – Polysaccharide Pneumococcal 23 valent Aboriginal*			
☐	**IPOL -** Poliomyelitis			
☐	**Havrix 1440/Havrix 720 –** Hepatitis A			
☐	**Engerix B/HBVAX II –** Hepatitis B			
☐	**Twinrix –** Hepatitis A and Hepatitis B			
☐	**Influenza**			
☐	**Other**			

Aboriginal* - inclusive of Aboriginal and Torres Strait Islander People

Immunisation providers name: _________________________________ Signature: ___________________________

Date: ____ Time: _______________________________

Comments: ____