EASTERN HEALTH AUTHORITY

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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

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
• Identifies as Aboriginal*	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 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

Aboriginal* - inclusive of Aboriginal and Torres Strait Islander People

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			
☐	**Pneumovax 23** – Polysaccharide Pneumococcal 23 valent			
☐	**IPOL -** Poliomyelitis			
☐	**Havrix 1440/Havrix 720 –** Hepatitis A			
☐	**Engerix B/HBVAX II –** Hepatitis B			
☐	**Twinrix –** Hepatitis A and Hepatitis B			
☐	**Influenza**			
☐	**Other**			

Immunisation providers name: _____ Signature: _____

Date: _____ Time: _____

Comments: _____