EASTERN HEALTH AUTHORITY
101 Payneham Road, St Peters SA 5069
PO Box 275 Stepney SA 5069
T 8132 3600
eha@eha.sa.gov.au
www.eha.sa.gov.au
ABN 52 535 526 438

Number:	Council:
Vaccines:	School:
Medicare:	Fee: $

IMMUNISATION CONSENT FORM

ADULT/ADOLESCENT (FROM 10 YEARS OF AGE)

If you do not hold a MEDICARE CARD, then a FEE PAYMENT is required before vaccination.

DETAILS OF PERSON TO BE VACCINATED (BLOCK LETTERS)

Family Name	
First Name	**Middle Initial**
Date of Birth	**Age** ☐ Male ☐ Female ☐ Other ☐ Aboriginal / Torres Strait Islander
Address	
Suburb	**Postcode**
Council Area	**Mobile**
School Attending	
Email Address	
Medicare Number	**Reference Number**

PLEASE TICK ✓ APPROPRIATE BOXES

• Is unwell today	☐ Yes ☐ No
• Is pregnant	☐ Yes ☐ No
• Is planning a pregnancy or anticipating parenthood	☐ 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
• Has had an injection of immunoglobulin, or received any blood products or whole blood transfusions within the past year	☐ Yes ☐ No
• Has a chronic medical condition (e.g. diabetes or have a disease which lowers immunity (e.g. oral steroid medicines; cortisone and prednisolone, is undergoing radiotherapy, chemotherapy), DMARDs (disease-modifying anti-rheumatic drugs)	☐ Yes ☐ No
• Is a parent, grandparent, or carer of an infant less than 6 months of age	☐ Yes ☐ No
• Do you have any medical condition relating to the functioning of your Spleen?	☐ Yes ☐ No
• Lives with someone who has a disease which lowers immunity (e.g. Leukaemia, cancer, HIV), or lives with someone who is having treatment which lowers immunity (Oral steroid medicine such as cortisone and prednisone, radiotherapy, chemotherapy, DMARDs (disease modifying anti rheumatic drugs)	☐ Yes ☐ No
• Has a bleeding disorder	☐ Yes ☐ No
• Is planning travel	☐ Yes ☐ No
• Has an occupation or lifestyle factors for which vaccination may be needed	☐ Yes ☐ No
• Has a history of Guillain-Barre syndrome (progressive paralysis)	☐ Yes ☐ No
• INFLUENZA VACCINE ONLY – Are you taking the following medications? Warfarin, Theophylline, Phenytoin, Aminopyrine	☐ Yes ☐ No

Please turn over →

YES - I have the opportunity to read the information on the immunisations required 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 ✓ which vaccines required **Below is office use only**

Tick	Vaccine	Batch No.	Site	Dose
☐	**Boostrix/Adacel** – Diphtheria, Tetanus and Pertussis (Whooping cough)			
☐	**Gardasil 9 –** Human Papillomavirus			
☐	**Bexsero** – Meningococcal B			
☐	**MenQuadfi–** Meningococcal ACWY			
☐	**Neisvac –** Meningococcal C			
☐	**Prevenar 13 –** Pneumococcal – ≥ 70 years			
☐	**Pneumovax 23** – Polysaccharide Pneumococcal 23 valent Aboriginal*			
☐	**Engerix B/HBVAX II –** Hepatitis B			
☐	**Priorix or MMR II –** Measles/Mumps/Rubella			
☐	**Varilrix/Varivax** – Varicella (Chicken Pox)			
☐	**IPOL -** Poliomyelitis			
☐	**Influenza**			
☐	**Havrix 1440/Havrix 720 –** Hepatitis A			
☐	**Abrysvo** – Respiratory Syncytial Virus (RSV) **Pregnant Women ONLY**			
☐	**Other -** Twinrix (Hepatitis A and Hepatitis B) or Shingrix			
☐	**Other**			

Aboriginal* - inclusive of Aboriginal and Torres Strait Islander People

Immunisation providers name: _____ Signature: _____

Date: _____ Time: _____

Comments: _____