

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

**ADULT/ADOLESCENT** (FROM 10 YEARS OF AGE)

## IMMUNISATION CONSENT FORM

**PLEASE COMPLETE CLEARLY USING BLOCK LETTERS**

**AS PER DETAILS ON MEDICARE CARD FOR THE PERSON BEING IMMUNISED**

Family Name																				
First Name																Middle Initial				
Date of Birth																Age		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Aboriginal and/or Torres Strait Islander		
Address																				
Suburb																Postcode				
Council Area											Mobile									
School Attending																				
Email Address																				
Medicare Number																Reference Number				

If you **DO NOT** hold a **MEDICARE CARD**, then a **FEE PAYMENT** is required before vaccination.

**PLEASE COMPLETE AND INDICATE IF THE PERSON TO BE VACCINATED**

• Is unwell today	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Is pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Is planning a pregnancy or anticipating parenthood	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Has had a severe reaction following any vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Has had <b>any</b> vaccine in the past month	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Has a severe allergy to anything	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Has had an injection of immunoglobulin, or received any blood products or whole blood transfusions within the past year	<input type="checkbox"/> Yes <input type="checkbox"/> 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))	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Is a parent, grandparent, or carer of an infant less than 6 months of age	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Do you have any medical condition relating to the functioning of your Spleen?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 (e.g. Oral steroid medicine such as cortisone and prednisone, radiotherapy, chemotherapy, DMARDs (disease modifying anti rheumatic drugs))	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Has a bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Is planning travel	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Has an occupation or lifestyle factors for which vaccination may be needed	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Has a history of Guillain-Barre syndrome (progressive paralysis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
• <b>INFLUENZA VACCINE ONLY</b> – Are you taking the following medications? Warfarin, Theophylline, Phenytoin, Aminopyrine	<input type="checkbox"/> Yes <input type="checkbox"/> No

**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 below which vaccines required**

**\*Below is office use only\***

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

Aboriginal\* - inclusive of Aboriginal and Torres Strait Islander People

Immunisation providers name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Comments: \_\_\_\_\_