EASTERN HEALTH AUTHORITY
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www.eha.sa.gov.au
ABN 52 535 526 438

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

CHILD (6 WEEKS to 9 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**		☐ Male ☐ Female ☐ Other ☐ Aboriginal and/or Torres Strait Islander											
Address																								
Suburb															**Postcode**									
Council Area											**Mobile**													
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	☐ 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 a bleeding disorder	☐ Yes ☐ No
• Was a pre-term infant (born before 37 weeks gestation)	☐ Yes ☐ No
• Is an infant of a mother who was receiving highly immunosuppressive therapy? (e.g. DMARDs biologic disease-modifying anti-rheumatic drugs) during pregnancy	☐ 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 any medical condition relating to the functioning of your Spleen?	☐ Yes ☐ No
• Has a chronic or severe medical condition e.g. diabetes or have a disease which lowers immunity (e.g. leukaemia, cancer, HIV,) or is having treatment that lowers immunity (e.g. oral steroid medicines such as prednisolone, cortisone, DMARDs (disease modifying anti rheumatic drug), radiotherapy, chemotherapy)	☐ 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 (e.g. Oral steroid medicine such as cortisone and prednisone, radiotherapy, chemotherapy, DMARDs (disease modifying anti rheumatic drug)	☐ 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

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 abovenamed 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: _____

Note: 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 or Vaxelis –** Haemophilus Influenzae Type B/ Hepatitis B/ Diphtheria/ Tetanus/ Pertussis/ Inactivated Poliomyelitis			
		Prevenar 13 – Conjugate Pneumococcal 13 valent			
		Rotarix – Oral Rotavirus vaccine			
		Bexsero – Meningococcal B			
☐	4 months	**Infanrix Hexa or Vaxelis –** Haemophilus Influenzae Type B/ Hepatitis B/ Diphtheria/ Tetanus/ Pertussis/ Inactivated Poliomyelitis			
		Prevenar 13 – Conjugate Pneumococcal 13 valent			
		Rotarix – Oral Rotavirus vaccine			
		Bexsero – Meningococcal B			
☐	6 months	**Infanrix Hexa or Vaxelis –** Haemophilus Influenzae Type B/Hepatitis B/ Diphtheria/ Tetanus/ Pertussis/ Inactivated Poliomyelitis			
☐	Aboriginal* or MAR*	**Prevenar 13 –** Conjugate Pneumococcal 13 valent			
☐	12 months	**Priorix or MMR II –** Measles/Mumps/Rubella			
		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	**Nimenrix –** Meningococcal ACWY			
☐	Other	**Influenza**			
☐	Other				

Immunisation provider name: _____ **Signature:** _____

Date: _____ **Time:** _____ **Comments:** _____