EASTERN HEALTH AUTHORITY
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PO Box 275 Stepney SA 5069
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www.eha.sa.gov.au
ABN 52 535 526 438

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** ☐ Male ☐ Female ☐ Other ☐ 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	☐ 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 (e.g. 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

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
☐	**Boostrix/Adacel** – Diphtheria, Tetanus and Pertussis (Whooping cough)			
☐	**Gardasil 9 –** Human Papillomavirus			
☐	**Bexsero** – Meningococcal B			
☐	**Nimenrix –** 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			
☐	**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: _____