

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		<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										
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
• Has had a severe reaction following any vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Has had any 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 a bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Was a pre-term infant (born before 37 weeks gestation)	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Is an infant of a mother who was receiving highly immunosuppressive therapy? (e.g. DMARDs biologic disease-modifying anti-rheumatic drugs) during pregnancy	<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
• Do you have any medical condition relating to the functioning of your Spleen?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<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 drug)	<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
• INFLUENZA VACCINE ONLY – 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 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
<input type="checkbox"/>	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			
<input type="checkbox"/>	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			
<input type="checkbox"/>	6 months	Infanrix Hexa or Vaxelis – Haemophilus Influenzae Type B/ Hepatitis B/ Diphtheria/ Tetanus/ Pertussis/ Inactivated Poliomyelitis			
<input type="checkbox"/>	Aboriginal* or MAR*	Prevenar 13 – Conjugate Pneumococcal 13 valent			
<input type="checkbox"/>	12 months	Priorix or MMR II – Measles/Mumps/Rubella Prevenar 13 – Conjugate Pneumococcal 13 valent Nimenrix – Meningococcal Conjugate ACWY Bexsero – Meningococcal B			
<input type="checkbox"/>	MAR*	HB VAX II or Engerix B – Hepatitis B paediatric			
<input type="checkbox"/>	18 months	Priorix-Tetra or Pro Quad – Measles/Mumps/Rubella/Varicella Infanrix or Tripacel – Diphtheria/ Tetanus/ Pertussis Act-HIB – Haemophilus Influenzae Type B			
<input type="checkbox"/>	18 months Aboriginal*	Vaqta – Hepatitis A			
<input type="checkbox"/>	4 years	Infanrix IPV or Quadracel – Diphtheria/ Tetanus/ Pertussis/ Inactivated Poliomyelitis			
<input type="checkbox"/>	MAR*	Pneumovax 23 – Polysaccharide Pneumococcal 23 valent			
<input type="checkbox"/>	4 years Aboriginal*	Pneumovax 23 – Polysaccharide Pneumococcal 23 valent Vaqta – Hepatitis A			
<input type="checkbox"/>	Other	Nimenrix – Meningococcal ACWY			
<input type="checkbox"/>	Other	Influenza			
<input type="checkbox"/>	Other				

Immunisation provider name: _____ Signature: _____

Date: _____ Time: _____ Comments: _____