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

CHILD (6 WEEKS to 9 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
• 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 medical condition or a disease which lowers immunity (e.g. diabetes; oral steroid medicines; cortisone and prednisolone; is undergoing radiotherapy; chemotherapy) or DMARDs, disease-modifying anti-rheumatic drugs)	☐ 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 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.

Please turn over ⟶

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 ☑ which vaccines are required **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 providers name: _____ Signature: _____

Date: _____ Time: _____

D24/1527