

## CONSENT FOR CHILDHOOD IMMUNISATION

Please read immunisation information before completing consent. Any queries regarding vaccination can be discussed with the Registered Nurse, prior to immunisation.

Child's Family Name: \_\_\_\_\_ First Name: \_\_\_\_\_ 2<sup>nd</sup> Initial \_\_\_\_\_

Address: \_\_\_\_\_ Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_

Medicare Number: (10 digit) \_\_\_\_\_ - \_\_\_\_\_ Ref No. \_\_\_\_\_ \* number next to name on card

Phone Number: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female

Do you identify as Indigenous or Torres Strait Islander? Yes / No (please circle)

Vaccine	Antigen	Age (please circle)	Site	Batch No
Rotatrix	Rotavirus	2mth 4mths	Oral	
Hexa	Tetanus Diphtheria whooping cough /HIB Hepatitis B and Polio	2mth 4mths 6mths	LL RL	
Prevenar 13	Pneumococcal	2mth 4mths 12mths	RL RA	
Bexsero	Meningococcal B	Dose 1 Dose 2 Dose 3	LL LA	
Nimenrix	Meningococcal ACWY	12 months	LA LL RA RL	
MMR PRIORIX, MMR II	Measles Mumps Rubella	12 months	LA LL RA RL	
Infanrix INFANRIX, TRIPACEL	Tetanus Diphtheria Whooping Cough	18 months	LA RA	
MMR/VV PRIORIXTETRA, PROQUAD	Chicken Pox/MMR	18 months	LA RA	
Act-HIB	Haemophilus influenzae Type B	18 months	LA RA	
IFX/IPV INFANRIX/IPV, QUADRACEL	Tetanus Diphtheria Whooping Cough, Polio	4 years	LA RA	
HAP	Hepatitis A	12months 18 months (Indigenous)	LA RA	
Prevenar 13	Pneumococcal	6 months medically at risk and Indigenous	LA RA	
Pneumococcal	Pneumovax 23	4 years medically at risk	LA RA	
Other			LA RA	

Office Use Only

Birth	2mth	4mth	6mths	12mths	18mths

RN Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ TIME \_\_\_\_\_

**Pre-vaccination Checklist Please indicate if the person to be vaccinated :**

- is unwell today  yes  no
- has a disease that lowers immunity (e.g. leukaemia, cancer, HIV/AIDS) or is having treatment that lowers immunity (e.g. medicines such as cortisone and prednisone, radio/chemotherapy)  yes  no
- is an infant of a mother who was receiving highly immunosuppressive therapy (e.g. biological disease modifying anti-rheumatic drugs (bDMARDs) during pregnancy  yes  no
- has had a severe reaction following any vaccine  yes  no
- has *any* severe allergies (to anything)  yes  no
- has had any vaccine in the past month  yes  no
- has had an injection of immunoglobulin, or received any blood products or a whole blood transfusion within the past year  yes  no
- is pregnant  yes  no
- has a past history of Guillain-Barré syndrome  yes  no
- was a preterm infant  yes  no
- has a chronic illness  yes  no
- has a bleeding disorder  yes  no
- does not have a functioning spleen  yes  no
- is planning a pregnancy or anticipating parenthood  yes  no
- is a parent or carer of a newborn  yes  no
- lives with someone who has a disease that lowers immunity (e.g. leukaemia, cancer, HIV/AIDS), or lives with someone who is having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy)  yes  no
- is planning overseas travel in the next 6 months  yes  no
- has an occupation or lifestyle factor(s) for which vaccination may be needed discuss with the nurse  yes  no

**I have read and understood the information given to me about immunisation including the risks of the vaccination and the risks of not being vaccinated. I have been given the opportunity to discuss the risks and benefits with my nurse. I request my child be immunised with the vaccines recommended in the immunisation schedule for pre-school aged children as indicated. I understand that consent can be withdrawn at any time. 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, HAIMS) and to the Australian Immunisation Register where it will be recorded on my Medicare account. I can contact my immunisation service provider (HAIMS) 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.**

**Are you the Parent / legal guardian  YES  NO Parent or legal guardian must complete consent form. If not, consent MUST be obtained verbally (by phone)**

**Name of person giving consent: \_\_\_\_\_ Signature: \_\_\_\_\_**

**Relationship to person being vaccinated: \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_**

<b>RN NOTES</b>