Health and Immunisation Management Services

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: _____2nd 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 Aboriginal or Torres Strait Islander (ATSI)? 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, MMR11	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	18 months & 4 years ATSI	**LA RA**	
Prevenar 13	Pneumococcal	6 months – ATSI, Medically at Risk	**LA RA**	
Pneumococcal	Pneumovax 23	4 years – ATSI, 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 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 _____/____/_____

RN NOTES

Date of issue: January 2023 Approved by Lee Frayne (Director)

Printed version may be superseded refer to Online Quality System for current version