Health and Immunisation Management Services

Clinic Immunisation Consent Form

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

Person to be vaccinated Family Name: _____Given Name _____

For secondary students only: School Site: _____ Year Level _____

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

Address: _____

Suburb: _____Postcode:_____

Phone Number: _____ Date of Birth____/____/____ Male ☐ Female ☐

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

Vaccine	Dose (please circle)	Site	Batch
dTpa **Adacel Boostrix**	**1**	**LA** **RA**	
HPV	**1**	**LA RA**	
Meningococcal B	**1 2**	**LA RA**	
Meningococcal ACWY **MenQuadfi**	**1**	**LA** **RA**	
MMR **PRIORIX MMR11**	**1 2**	**LA** **RA**	
Varicella (Chicken Pox) **Varilrix Varivax**	**1 2**	**LA** **RA**	
Hepatitis A	**1 2**	**LA RA**	
Hepatitis B	**1 2 3**	**LA RA**	
Hepatitis A&B	**1 2 3**	**LA RA**	
IPV	**1 2 3**	**LA RA**	
Prevenar 13	**1 2**	**LA** **RA**	
Shingrix	**1 2**	**LA RA**	
Abrysvo (RSV)		**LA RA**	
Influenza		**LA RA**	
Other		**LA RA**	

RN Signature _____Date _____/_____/_____**TIME GIVEN**_____

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.

If the person to be vaccinated is under 16 years of age

Parent or legal guardian must complete consent form. If not, consent MUST be obtained verbally (by phone)

Relationship to person being vaccinated: ☐ **Mother** ☐ **Father** ☐ **Legal Guardian** ☐ **Other** _____
Please check box

Surname of person giving consent: _____ _____

First name of person giving consent _____

Signature _____ **DATE** _____/____/_____

RN NOTES

Date of issue: January 2025 Approved by Lee Frayne (Director)

Printed version may be superseded refer to Online Quality System for current version