PLEASE USE DETAILS AS SHOWN ON MEDICARE ONLY

Adult and student consent form for Immunisation

Consent Form – doc/19/86201
(updated August 2020)
Adult Immunisation/16 yrs and over
Including catch-up school

Client surname: First name:

Address:

Postcode: Mobile number:

Email: Date of birth: Age:

Male ☐ Female ☐ Are you of Indigenous or Torres Strait Islander descent? Yes ☐ No ☐

Please note any allergies:

Medicare number: Reference number on card:

HIGH SCHOOL STUDENTS ONLY

School attending: Year level:

Vaccine requested: (Please tick)

Boostrix/Adacel (Diphtheria, Tetanus & Whooping Cough) ☐	**Gardasil (Human Papillomavirus HPV)** Dose 1 ☐ 2 ☐
Varivax/Varicella (Chickpox) Dose 1 ☐ 2 ☐	**Nimenrix** (Meningococcal ACWY) ☐
Pneumovax 23 (Pneumococcal) ☐	**Bexsero (Meningococcal B)** Dose 1 ☐ 2 ☐
Prevenar 13 (Pneumococcal) ☐	**Other** ☐
HB-VaxII/Engerix B (Hepatitis B) Dose 1 ☐ 2 ☐	

Consent for Vaccination

I have read and understood the information given to me about immunisation including the risks and benefits. I have been given the opportunity to discuss this with my Nurse. I consent for the above named to be vaccinated with the vaccines ticked above. 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 staff involved in the provision of an immunisation service for SA Health and local government councils (and their immunisation service providers) and to the Australian Immunisation Register, where it will be stored on the client's Medicare Account.
I can contact my immunisation service provider if I am concerned personal information has been misused or subject to unauthorised access.

Client signature _____ Date: _____

Client name _____

Office use only: Record of Vaccination: Nurse signature Date Time

LA / RA LL/RL Dose #	LA / RA LL/RL Dose #	LA / RA LL/RL Dose #	LA / RA LL/RL Dose #
Batch#	Batch#	Batch#	Batch#

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Prevaccination checklist

Are you well today?

Yes ☐ No ☐

Do you have any bleeding disorder or other severe or chronic illness?

Yes ☐ No ☐

Are you taking any medicines? E.g. antibiotics or blood thinning medications

Yes ☐ No ☐

Are you allergic to any foods or medicines?

Yes ☐ No ☐

Have you ever had a reaction after having any vaccine?

Yes ☐ No ☐

Have you ever fainted or felt dizzy after having an injection?

Yes ☐ No ☐

Could you be pregnant? (for those who identify as female on consent form)

Yes ☐ No ☐

Have you had any other vaccines or needles since completing the consent card?

Yes ☐ No ☐
