Consent Form: Doc Set ID: 795679
(updated June 2020)
Childhood Immunisation
(6 weeks -15 yrs) or current school program

PLEASE USE DETAILS AS SHOWN ON MEDICARE ONLY

Immunisation Consent Form: Child and high school students

Parent/Legal Guardian to complete this form

Child surname: Child 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)

6 weeks	DTPa/IPV/HIB/HEPB, PV, Oral RVV, Men B ☐	**Year 8**	Diptheria/Tetanus/Pertussis (Boostrix) ☐
4 months	DTPa/IPV/HIB/HEPB, PV, Oral RVV, Men B ☐	**Year 8** **Dose**	Human Papillomavirus HPV (Gardasil) ☐ 1 ☐ 2 ☐
6 months	DTPa/IPV/HIB/HEPB ☐		
12 months	MMR, MEN ACWY, PV, Men B ☐	**Year 10**	Meningococcal ACWY (Nimenrix) ☐
18 months	MMRV, DTP, HIB ☐	**Year 10** **Dose**	Meningococcal B (Bexero) ☐ 1 ☐ 2 ☐
4 years	DTPa/IPV ☐	**Other:**	

For under 2 yrs (Meningococcal B) – Paracetamol has been given prior to vaccination: YES ☐ NO ☐
Panadol Management Discussed: YES ☐

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 immuisation 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.

Parent/Legal Guardian Signature ______________________ Date: ____________

Parent/Legal Guardian Name ______________________ Date: ____________

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#

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 ☐