Health & Immunisation

Management Services

AIR	IMPS	

Consent for Adult/Adolescent Immunisation

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)*

Yes 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 to be immunised with the vaccines as indicated below. I understand that consent can be withdrawn at any time. It **is advisable to wait 15 minutes after vaccination.**

Vaccine	Dose (please circle)	Site	Batch	RN Signature
HPV	1 2 (3)	LA RA		
dTpa	1	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		
MMR	1 2	LA RA		
Varicella (Chicken Pox)	1 2	LA RA		
Influenza		LA RA		
Other		LA RA		

For clients under 16 years of age: Are you the Parent of legal guardian? ☐ **YES** ☐ **NO**

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

Signature: ______________________ Print Name: _____________________________________ DATE __/ __/ ___

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 travel ☐ yes ☐ no

- has an occupation or lifestyle factor(s) for which vaccination may be needed (discuss with doctor/nurse) ☐ yes ☐ no

Please specify: ____

Note: Please discuss this information or any questions you have about vaccination with the nurse before the vaccines are given

Comments