Immunisation Consent Form

CHILD (Birth to under 10years)

Name: _____ Age: _____

First Name Middle Name Surname

☐ Male ☐ Female **Date of Birth:** _ _/_ _/_ _ Parents Name: _____

First Name Surname

Address: _____ Suburb: _____ Post Code: _____

☐ Aboriginal ☐ Aboriginal & Torres Strait Islander (TSI) ☐ TSI ☐ Non Indigenous

Contact Number: _____ Email: _____

Medicare: ☐☐☐☐☐☐☐☐☐☐ Ref No: ☐

Pre-Vaccination Checklist (Please Tick)

		YES	NO
1.	Is your child unwell today?	☐	☐
2.	Has your child ever had a reaction to any vaccine?	☐	☐
3.	Does your child have any severe allergies?	☐	☐
4.	Has your child had a live vaccine (including BCG, MMR, Chickenpox, Rotavirus or Yellow Fever) within the past month?	☐	☐
5.	Has your child had an injection of Immunoglobulin or Blood Transfusion in the last 12 months?	☐	☐
6.	Does your child have a disease which lowers immunity, (eg leukaemia, cancer, HIV/AIDS, lymphoma, TB, Hodgkin's disease), or receiving a treatment which lowers immunity, (e.g. chemotherapy or radiotherapy)?	☐	☐
7.	Does your child live with someone who has one of the above diseases or is receiving any of the above treatments?	☐	☐
8.	Does your child have a chronic illness or bleeding disorder?	☐	☐
9.	Does your child identify as Aboriginal or Torres Strait Islander (if yes, please circle to identify)	☐	☐
10.	At birth, was your child born less than 32 weeks gestation or less than 2000g birth weight?	☐	☐

Before vaccination, please discuss with the nurse if any of the above conditions apply to the person being vaccinated. The conditions do not necessarily exclude vaccination but should be considered by the nurse giving the vaccine. Every person immunised must wait for a minimum of 15 minutes after immunisation in case of an adverse reaction.

Consent/Authority

- I have read and understood the information page comparing the side effect of vaccines to the effects of the diseases and have had the opportunity to discuss this with the nurses.
- The information completed by me on this form is true and correct to the best of my knowledge.
- I am authorised to request and give consent for vaccination.

Logan City Council is collecting your name, address, contact and, if required, payment details for the purpose of processing your vaccination record. The information will only be accessed by employees and/or Councillors of Logan City Council. The information will be given to The Australian Immunisation Register and accessed by SmartVax (a vaccine safety and surveillance system). Your information will not be given to any other person or agency unless you have given us permission or we are required by law.

What is your relationship to the child?

☐ Parent ☐ Legal Guardian ☐ A person with authorisation from the Parent/Legal Guardian

By signing this form you agree to have your child vaccinated by Logan City Council.

Signature: _____ Date: _____

Office Use Only (Nurses, please check, tick and sign)	
☐ Name Checked	☐ Date of Birth Checked
☐ Pre-vaccination checklist reviewed	☐ Risk Factors documented
Nurse Name & Signature:	

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Office Use Only

Doc # 12233992

Is this child on a Catch-Up schedule? YES NO

If yes, Catch-Up #: _____ Reason: _____

2, 4 & 6 Months	Office Use Only (DOSE- please circle)
☐ **Infanrix Hexa®** (Diphtheria, Tetanus, Pertussis, Hepatitis B, Inactivated Polio & Haemophilus Influenzae B)	1 2 3
☐ **Prevenar13®** (Pneumococcal) *(Dose 3 for ATSI & Med @ Risk)*	1 2 3
☐ **Rotarix®** (Rotavirus)	1 2

12 Months *(Nurses, please circle the brand of vaccine)*	Office Use Only (DOSE- please circle)
☐ **Priorix® or MMR II®** (Measles, Mumps & Rubella)	1
☐ **Nimenrix®** (Meningococcal A,C,W,Y)	1
☐ **Prevenar13®** (Pneumococcal) *(Dose 4 for ATSI & Med @ Risk Only)*	3 4
☐ ***HB Vax II Paediatric®** (Hepatitis B – if Birth Weight <2000g)*	4
☐ ***Vaqta Paediatric®** (Hepatitis A – for ATSI)*	1

18 Months *(Nurses, please circle the brand of vaccine)*	Office Use Only (DOSE- please circle)
☐ **ProQuad® or PriorixTetra®** (Measles, Mumps, Rubella & Varicella)	2
☐ **Infanrix® or Tripacel®** (Diphtheria, Tetanus & Pertussis)	4
☐ **Act-HIB®** (Haemophilus Influenzae B) ***(if not given @12mths)***	4
☐ ***Vaqta Paediatric® (Hepatitis A – for ATSI only)***	2
☐ ***Prevenar 13® (Pneumococcal – for ATSI & Med @ Risk only) (if not given @12 mths)***	4

4 Years *(Nurses, please circle the brand of vaccine)*	Office Use Only (DOSE- please circle)
☐ **InfanrixIPV® or Quadracel®** (Diphtheria, Tetanus, Pertussis & Inactivated Polio)	4 5
☐ ***Pneumovax 23® (Pneumococcal – Medically @ Risk)***	4 5

Influenza *(6mths – 3yrs require Paediatric 0.25ml Dose)*

☐ **Brand Name:** **0.25ml OR 0.5ml** 1 2 ☐ **PAID** ☐ **FREE**

(2nd dose required the first year a child <9yrs receives the influenza vaccine)

Catch-Up Vaccines (Nurses, circle brand & dose) Other: _____

HB VAX II (Paed) 1 2 3 MMRII/Priorix 1 2 Varilrix/Varivax 1 2 InfanrixIPV 1 2 3

Office Use Only

The parent / legal guardian or authorised person of the child to be vaccinated:

- Was given the opportunity to discuss the risks and benefits of the vaccination. ☐ **Yes**

Nurse Name & Signature:_____ Date: _____

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