lmn	nunisation (Consent Form						
C	HILD	(Birth to under 10years	O f □ □					
Name	e:					Age:		
	First Nam	e Middle	Name Surr	ame				
□ Ма	ale 🗆 Female	Date of Birth:/_	Pare	nts Name:	First Name	Surname	e	
Addre	ess:		Suburb: _			_ Post Code:		
Г	☐ Aboriginal	☐ Aboriginal & Torres	Strait Islander	☐ Torres Str	ait Islander	☐ Non In	ıdigenou	ıs
	act Number:		Email:				u.goou	
Medic				Ref No:				
Pre	-Vaccination C	hecklist (Please Tic	k)				YES	NC
1.	Is your child unw	•						
2. 3.		ver had a reaction to any ver nave any severe allergies?						L
4.	-	ad a live vaccine (including		oox. Rotavirus or	Yellow Fever) v	vithin the past	- Ш	_
	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/condition which lowers immunity, (eg asplenia, leukaemia, cancer, HIV/AIDS, lymphoma, TB, Hodgkin's disease), or receiving a treatment which lowers immunity, (e.g. chemotherapy or radiotherapy)?							
7.	• • •							
8.	Does your child have a chronic illness or bleeding disorder?							
9.	-	dentify as Aboriginal or To		-			_ 🗆	
10.	10. At birth, was your child born less than 32 weeks gestation or less than 2000g birth weight?							
should	be considered by the nuent/Authority	uss with the nurse if any of the arse giving the vaccine. Every per	son immunised must wait for a	a minimum of 15 minut	es after immunisation	on in case of an advers	se reaction.	l.
	to discuss this The informatio	d understood the information with the nurses. n completed by me on this fod to request and give consen	rm is true and correct to the			diseases and have n	ad the op	portur
access	ed by employees and/or	your name, address, contact an Councillors of Logan City Counc Your information will not be give	cil. The information will be gi	ven to The Australian	Immunisation Regis	ster and accessed by S	SmartVax (
	is your relationshi	<u></u>	ian 🔲	A norman with a	therication from	the Derent/Lege	l Cuardi	.
		☐ Legal Guard agree to have your child		-	นางกอสแบบ ทบท	n the Parent/Lega	Guarula	ЯΠ
Signa	ture:			Date:				
Offic	ce Use Only (Nur	ses, please check, tick a	nd sign)					
	Name Checked			Date of Birth Che	ecked			
	Pre-vaccination che	ecklist reviewed		Risk Factors doc	umented			
Nu	rse Name & S	ignature:						



Office Use Only

Doc # 12233992

Is this	s child on a Catch-Up schedule? YES NO If yes, Catch-Up #:	Reason:					
2, 4 &	6 Months	Office Us	e Only	(DOSE pl	ease c	ircle)	
	Infanrix Hexa® (Diphtheria, Tetanus, Pertussis, Hepatitis B, Inactivated Polio & Haemophilus Influenzae B)	1 _{RL}		2 _{RL}	3	RL	
	Prevenar13® (Pneumococcal) (Dose 3 for Indigenous &/or Med @ Risk)	1 LL		2 _{LL}	3	LL	
	Rotarix® (Rotavirus)	1 Ora	ı [2 _{Oral}			
	Bexsero (Meningococcal B) (Indigenous &/or Med @ Risk)	1 _{RL}		2 _{RL}	3	RL FREI	
	Nimenrix® (Meningococcal A,C,W,Y) Med @ Risk	1 LL		2 LL	'	-	
12 Mor	nths (Nurses, please circle the brand of vaccine)	Office Us		(DOSE pl	ease c	ircle)	
	Priorix® or MMR II® (Measles, Mumps & Rubella)	1 LA					
	Nimenrix® (Meningococcal A,C,W,Y) Med @ Risk	1 LA		3 LA			
	Prevenar13® (Pneumococcal) (Dose 4 for Indigenous &/or Med @ Risk Only)	3 RA		4 RA			
	Bexsero (Meningococcal B) (Indigenous &/or Med @ Risk)	1 RA		2 RA	3	RA	
	HB Vax II Paediatric® (Hepatitis B – if Birth Weight <2000g)	4 RA L	A RL LI			<u>-</u>]115	
18 Mor	nths (Nurses, please circle the brand of vaccine)	Office Us	e Only	(DOSE pl	ease c	ircle)	
	ProQuad® or PriorixTetra® (Measles, Mumps, Rubella & Varicella)	2 _{LA}					
	Infanrix® or Tripacel® (Diphtheria, Tetanus & Pertussis)	4 _{RA}					
	Act-HIB® (Haemophilus Influenzae B)	4 _{LA}					
	Vaqta Paediatric® (Hepatitis A – for Indigenous)	1 RA					
4 Year	s (Nurses, please circle the brand of vaccine)	Office Us	e Only	(DOSE pl	ease c	ircle)	
	InfanrixIPV® or Quadracel® (Diphtheria, Tetanus, Pertussis & Inactivated Polio)	5 _{LA}					
	Pneumovax 23® (Pneumococcal – (Indigenous &/or Med @ Risk) (refer to NIP Pneumococcal Decision Tree)	5 RA					
	Vaqta Paediatric® (Hepatitis A – for Indigenous)						
	vaqta i accitatio (inchatitis A = 101 indigenous)	2 LA					
Influ	enza (6mths 3yrs require Paediatric 0.25ml Dose)						
_	Brand Name: 0.5ml		DΛ			PAID	
	Brand Name: 0.5ml Has the child received the influenza vaccine in a previous year? Yes or No If no, a 2nd dose is required if the child is <9yrs		RA RL	2		FREE	
Catc	h Up Vaccines (Nurses, circle brand & dose) Other:						
HB V	AX II 1 2 3 MMRII/Priorix 1 2 Varilrix/Varivax 1 2 InfanrixIP	V 12	3 Bex	sero (Indige	enous	1234	
(Paed	I) RA LA RA LA RA LA	RA L	A Chil	dren < 2 yrs	s)	RA LA RL LL	
	Use Only						
	arent / legal guardian or authorised person of the child to be vaccinated: Vas given the opportunity to discuss the risks and benefits of the vaccination.		☐ Yes				



Date:

Nurse Name & Signature:_