BRISBANE CITY COUNCIL ABN 72 002 765 795

Catch up ☐

Immunisation Consent

Dedicated to a better Brisbane

IMPORTANT: *Please complete all sections of the form. More detailed information on the risks and benefits of these vaccinations is available – please ask Brisbane City Council staff.*

1 Personal details of the person being vaccinated ***Please print***

Full name

Surname/Family name | First/Given name/s

Date of Birth / / | Background: Aboriginal ☐ Torres Strait Islander ☐ Refugee ☐

Gender: Male ☐ Female ☐ Other ☐ | Medicare no. __ __ __ __ __ __ __ __ __ __ / __

Address

Unit no. | Street no. | Street name | Suburb | Postcode

Email | Phone no.

2 Are you the person being vaccinated?

Yes ☐

No ☐ I am the parent ☐ I am the legal guardian ☐ Full name of parent/legal guardian

3 Vaccine/s required ***Tick box/es or specify other***

OFFICE USE ONLY

ROTAVIRUS ..... *6 weeks, 4 months* ☐

DTPa-IPV-HIB-HEP B Diphtheria, Tetanus, Whooping Cough, Inactivated Polio, Haemophilus Influenzae B, Hepatitis B ..... *6 weeks, 4 months, 6 months* ☐

PNEUMOCOCCAL ..... *6 weeks, 4 months, 12 months* ☐

Men ACWY Meningococcal ..... *12 months* ☐

MMR Measles, Mumps, Rubella ..... *12 months* ☐

Men B Meningococcal ..... *various* ☐

HIB Haemophilus Influenzae B ..... *18 months* ☐

MMRV Measles, Mumps, Rubella, Varicella ..... *18 months* ☐

DTPa Diphtheria, Tetanus, Whooping Cough ..... *18 months* ☐

DTPa-IPV Diphtheria, Tetanus, Whooping Cough, Inactivated Polio ..... *4 years* ☐

dTpa Diphtheria, Tetanus, Whooping Cough ..... *Adult booster* ☐

Pneumococcal ..... *Adult* ☐

Varicella Zoster (Shingles) ..... *Adult* ☐

Influenza ..... ☐

School vaccines ..... ☐

OTHER *Please specify*

Pre-vaccination checklist: Before vaccination, please discuss with the nurse if any of the following conditions apply to the person being vaccinated. The conditions do not necessarily exclude vaccination, but should be considered by the nurse giving the vaccination.

4 Is the person being vaccinated feeling sick today?

No ☐ Yes ☐ *Please describe*

5 Has the person being vaccinated had a reaction following any vaccine?

No ☐ Yes ☐ *Please describe*

6 Does the person being vaccinated have any allergies?

No ☐ Yes ☐ *Please describe*

7 Is the person being vaccinated taking any medicine prescribed by a doctor, e.g. *corticosteroid medicine such as cortisone or prednisone*?

No ☐ Yes ☐ *Please describe*

8 **In the last month** has the person being vaccinated had a live vaccine (including BCG, MMR, Rotavirus or Yellow Fever)?

No ☐ Yes ☐ *Please describe*

9 **In the last 12 months** has the person being vaccinated had an injection of immunoglobulin or blood transfusion?

No ☐ Yes ☐ *Please describe*

10 Does the person being vaccinated have a disease/chronic illness or a condition which lowers immunity, e.g. *leukaemia, cancer, HIV/AIDS, asthma, diabetes* or is receiving treatment which lowers immunity, e.g. *chemotherapy or radiotherapy*?

No ☐ Yes ☐ *Please describe*

11 Is the person being vaccinated pregnant or planning to become pregnant?

No ☐ Yes ☐

12 At birth, was the person being vaccinated less than 32 weeks gestation or 2000g birth weight?

No ☐ Yes ☐ *Please describe* N/A ☐

13 Consent/Authority

- I have read and understood the information page comparing the effects of the diseases and the side effects of the various vaccinations and the Advice Sheet about common reactions to the vaccinations and what to do about them.
- I have had an opportunity to discuss any concerns about the effects of the diseases, the vaccination and their side effects and the common reactions to the vaccinations with the nurse.
- 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 as stated in the following points.
- I request and consent to myself/the child being immunised with the vaccines ticked in the list on the front of this form.
- In order to obtain this service, I acknowledge and consent to vaccination information being collected by Brisbane City Council for immunisation purposes and provided to the Australian Immunisation Register.

14 Name and signature of person completing this immunisation consent and pre-vaccination checklist

Full name

Relationship to child *If applicable*

Signature and date

/ /

OFFICE USE ONLY

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

Was given an opportunity to discuss the risks and benefits of the vaccination?

No ☐ Yes ☐

Needed more information?

No ☐ Yes ☐

Required translation material/translator?

No ☐ Yes ☐

Summary of additional information

Pre vaccination info sheet given ☐

Vaccine Provider's signature and date

/ /