CONSUMER VACCINATION PRE-SCREENING/ CONSENT & RECORDING FORM

1.PERSONAL DETAILS (PERSON TO BE VACCINATED)

Name:	Medicare Number:
Address:	
Phone Number:	Email:
Date of Birth:	Gender: ○ F ○ M ○ Prefer not to say

2.PRE-VACCINATION SCREENING CHECKLIST

(ref. Australian Immunisation Handbook)

☐ Are unwell today (Will be confirmed at time of vaccination)	☐ Identify as an Aboriginal or Torres Strait Islander	☐ Have had a severe reaction following any vaccine
☐ Have a chronic illness	☐ Are pregnant or planning pregnancy	☐ Have any severe allergies to anything (anaphylactic)
☐ Have a disease that lowers immunity (e.g. leukemia, cancer, HIV/AIDS) or are having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy)	☐ Have a bleeding disorder (or take any medications which may increase the risk of bleeding)	☐ Had any blood transfusions in the past year
	☐ Do not have a functioning spleen	Please list below any vaccinations you have received in the last month:
	☐ Are a parent, grandparent or carer of an infant ≤6 months of age	.....
☐ Have a history of Guillain-Barre syndrome	☐ Have ever fainted after having an injection?	.....

3.CONSENT TO RECEIVE IMMUNISATION

I have been given, and understand the information provided to me regarding the vaccine and possible side effects. If I have further questions, I will ask the immuniser before I am immunised. I consent to receiving the: ..... Influenza ..... vaccine. I consent to a copy of my Statement of Immunisation being provided to my nominated medical practitioner ○ Yes ○ No	I understand: • I must remain within the designated waiting area for a period of 15 minutes after vaccination for observation and so that I may receive additional medical attention, including emergency care, if needed. • This service will be recorded on the Australian Immunisation Register. • I have been advised of, and agree to pay the charges associated with this service.
Signature:	Date: Name:

RECORD OF _____ IMMUNISATION (Immuniser use only)

Date:	Vaccine Brand:	Batch:	Expiry:
Time:	Pre/post vaccination counselling ☐ Yes ☐ No		Adverse event (if any):
Injection Site: Arm: ☐ Left ☐ Right ☐ Other	Statement of immunisation given ☐ Yes ☐ No		Treatment given:
	GP notified (fax/email) ☐ Yes ☐ No		WAVSS notified of adverse event ☐ Yes ☐ No
Immuniser:	Signature:		Accreditation Number: