



## Consumer Vaccination Pre-Screening/ Consent & Recording Form

Pharmacy details:	Unique reference number:
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### 1. PERSONAL DETAILS (PERSON TO BE VACCINATED)

Full Name			
Address			
Email			
Contact Phone Number			
Medicare number			
Date of Birth			<input type="checkbox"/> Male <input type="checkbox"/> Female

### 2. PRIMARY MEDICAL PRACTITIONER (OPTIONAL)

Doctor		Phone	
Address			
Email			

### 3. PRE-VACCINATION SCREENING CHECKLIST *(reference: Australian Immunisation Handbook online)*

Please indicate if you/ your child (the person to be vaccinated today):

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

#### 4. 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 myself/my child is immunised.

I consent to myself/my child receiving the \_\_\_\_\_ vaccine.

I understand:

- I/my child must remain within the pharmacy premises 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.

I consent to a copy of my Statement of Immunisation being provided to my nominated medical practitioner

Yes  No

Signature:

Name:

Date:

RECORD OF _____ IMMUNISATION (Immuniser use only)		
Date:	Time:	
Vaccine Brand:	Injection Site: <input type="checkbox"/> Left arm <input type="checkbox"/> Right arm	Batch number: Expiry date:
Adverse event experienced (if any):	Treatment given:	WAVVS notified of adverse event. <input type="checkbox"/> Yes <input type="checkbox"/> No
Pre/post vaccination counselling <input type="checkbox"/> Yes <input type="checkbox"/> No	Notes:	
Statement of immunisation given <input type="checkbox"/> Yes <input type="checkbox"/> No	Doctor notified (fax/email/phone) <input type="checkbox"/> Yes <input type="checkbox"/> No	Doctor details:
Signature:	Date:	Accreditation Number: