# Consumer Vaccination Pre-Screening/Consent & Recording Form

**Pharmacy details:**

<table>
<thead>
<tr>
<th>Unique reference number:</th>
</tr>
</thead>
</table>

## 1. PERSONAL DETAILS (PERSON TO BE VACCINATED)

<table>
<thead>
<tr>
<th>Full Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td></td>
</tr>
<tr>
<td>Contact Phone Number</td>
<td></td>
</tr>
<tr>
<td>Medicare number</td>
<td></td>
</tr>
</tbody>
</table>

**Date of Birth**

- [ ] Male
- [ ] Female

## 2. PRIMARY MEDICAL PRACTITIONER (OPTIONAL)

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Email</td>
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</tbody>
</table>

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

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

- [ ] Are unwell today
- [ ] 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. leukaemia, 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
- [ ] Are a parent, grandparent or carer of an infant ≤6 months of age

- [ ] Have a history of Guillain-Barré syndrome
- [ ] Please list below any vaccinations you have received in the last month
- [ ] 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:  ❑ Left arm  ❑ Right arm

Batch number:  Expiry date:

Adverse event experienced (if any):  Treatment given:  WAVVS notified of adverse event.  ❑ Yes  ❑ No

Pre/post vaccination counselling  ❑ Yes  ❑ No  Notes:

Statement of immunisation given  ❑ Yes  ❑ No  Doctor notified (fax/email/phone)  ❑ Yes  ❑ No  Doctor details:

Signature:  Date:  Accreditation Number: