Queensland Government

Gold Coast Health | Public Health Unit

Immunisation Consent Form

Person being immunised – 10 years and over

Surname / Family Name: _____

Given / First Name/s: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female

Medicare No: ☐☐☐☐☐☐☐☐☐☐ Ref No.: ☐

Home Address: _____

Suburb & Post Code: _____

Mobile No.: _____ **Email:** _____

Is Person of Aboriginal or Torres Strait Islander origin? *Your accurate response to the Indigenous status question assists Qld Health in delivering the best possible health care to all patients.*

☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, Aboriginal & Torres Strait Islander ☐ No

If you are consenting as a parent, legal guardian or other authorised person, please provide your name:

Surname / Family Name: _____

Given / First Name/s: _____

Pre-Immunisation Checklist:

Before immunisation, please discuss with the nurse if any of the conditions below apply to the person being immunised.

- ☐ Is unwell today
- ☐ Has had a severe reaction following any vaccine *If so, please specify*: _____
- ☐ Has a chronic illness: _____
- ☐ Has a medical condition: _____
- ☐ Has any severe allergies to anything: _____
- ☐ Is pregnant or planning pregnancy. How many weeks? _____
- ☐ Has had a vaccine in the last month: _____
- ☐ Has a disease that lowers immunity (e.g. leukaemia, cancer, HIV) or is having treatment that lowers immunity (e.g. oral steroid medication such as cortisone and prednisone, DMARDs [disease-modifying anti-rheumatic drugs], radiotherapy, chemotherapy): _____
- ☐ Having treatment (or lives with someone having treatment) that lowers immunity (e.g. steroid medication, radiotherapy, chemotherapy): _____
- ☐ Has had an injection of immunoglobulin or received any blood products within the past year
- ☐ Has a past history of Guillain-Barre syndrome
- ☐ Has a bleeding disorder
- ☐ Does not have a functioning spleen
- ☐ Is planning to travel

Every person vaccinated must **wait at the clinic for a minimum of 15 minutes after** immunisation in case of an adverse reaction

I have read and understood the information provided regarding the benefits and possible side effects of the vaccines to the effects of the disease and have had the opportunity to discuss with the nurse. I acknowledge that the vaccination details provided will be recorded on the Australian Immunisation Register (AIR). Information completed by me is true and correct to the best of my knowledge.

Price list for non-scheduled vaccines: www.goldcoast.health.qld.gov.au/our-services/immunisation/free-community-immunisation-clinics

I hereby give consent for myself / my child to be vaccinated at the GCPHU clinic:

Signature: _____ Date: _____/_____/_____

Gold Coast Public Health Unit (GCPHU) is collecting you/your child's personal information to record vaccination details on the Australian Immunisation Register (AIR). Your information will not be accessed or given to any other person or organisation without your permission unless permitted or required by law. Vaccines are rigorously tested in Australia. GCPHU wish to monitor responses to these vaccines by text messaging you/parents after you/children are immunised. Please complete your mobile phone number on this consent form so this can occur. For further information about how Queensland Health protects your personal information visit www.health.qld.gov.au.

Vaccine *(office use only – please circle)*	Dose	Dose	Dose	Dose	Paid / Free	Clinical Notes
Adacel® / Boostrix® (*Diphtheria / Tetanus / Pertussis*)	1	2	3	5		
Bexsero® (*Meningococcal B*)	1	2	3			
Havrix® (*Hepatitis A*)	1	2				
Engerix B® / HBVaxII® (*Hepatitis B*)	1	2	3			
Gardasil 9® (*Human Papillomavirus)*	1	2	3			
Influenza	1					
IPOL® *(Inactivated Polio)*						
Menactra® / Nimenrix® *(Meningococcal ACWY)*	1	2				
Prevenar 13® *(Pneumococcal)*	1					
Pneumovax 23® *(Pneumococcal)*	1					
Priorix® / MMRII® *(Measles / Mumps / Rubella) Free if born after 1966 – 2 doses required, 1 month apart*	1	2				
Twinrix® *(Hepatitis A & B)*	1	2	3			
Varivax® / Varilrix® *(Varicella (Chickenpox))*	1	2				

Adacel® / Boostrix® Dose #	Batch # RA LA RL LL Nurse Signature:	**Bexsero®** Dose #	Batch # RA LA RL LL Nurse Signature:	**Havrix®** Dose #	Batch # RA LA RL LL Nurse Signature:	**Engerix B® / HBVaxII®** Dose #	Batch # RA LA RL LL Nurse Signature:
Gardasil 9® Dose #	Batch # RA LA RL LL Nurse Signature:	**Influenza** Dose #	Batch # RA LA RL LL Nurse Signature:	**IPOL®** Dose #	Batch # RA LA RL LL Nurse Signature:	**Nimenrix®** Dose #	Batch # RA LA RL LL Nurse Signature:
Pneumovax 23® Dose #	Batch # RA LA RL LL Nurse Signature:	**Prevenar 13®** Dose #	Batch # RA LA RL LL Nurse Signature:	**Priorix® / MMRII®** Dose #	Batch # RA LA RL LL Nurse Signature:	**Twinrix®** Dose #	Batch # RA LA RL LL Nurse Signature:
Varivax® / Varilrix® Dose #	Batch # RA LA RL LL Nurse Signature:	Dose #	Batch # RA LA RL LL Nurse Signature:	Dose #	Batch # RA LA RL LL Nurse Signature:	Dose #	Batch # RA LA RL LL Nurse Signature:
School Name / College Name / Home Schooled *(please indicate)*						**Current Year Level:**	

Clients Age:	☐ Pre Vaccination ☐ Post Vaccination ☐ Reaction/s and ☐ Vaccine Information ☐ Post Immunisation Record *has been provided to client / parent / legal guardian* IPN Name (Please Print / Use Stamp): _____ Date: _____/_____/_____	Time vaccinated: AM / PM