MOUNT BARKER
DISTRICT COUNCIL

**Parent/Legal Guardian to complete both sides of this form**

Consent Form
Childhood Immunisation
**6weeks-15 yrs**

***AS SHOWN ON MEDICARE ONLY***

Surname | First Name | Middle Initial

Address | Postcode

Contact Number | Date of Birth | Age

Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither ☐

Male ☐ Female ☐

Medicare Number ☐☐☐☐☐☐☐☐☐☐ Reference No. on Card ☐

***HIGH SCHOOL STUDENTS ONLY***

School Attending | Current Year Level ☐

**Office use only below this line**

| | | **0-4yrs Program** | | **High School Program** | |
|---|---|---|---|---|---|
| 2 mths | | DTPa/IPV/HIB/HEPB, PV, Oral RVV | | | Dose |
| 4 mths | | DTPa/IPV/HIB/HEPB, PV, Oral RVV | | | Dose |
| 6 mths | | DTPa/IPV/HIB/HEPB | | | Dose |
| 12 mths | | MMR, MEN ACWY, PV | | | |
| 18 mths | | MMRV, DTP, HIB | | **SA Bexsero Program (Childhood)** | |
| 4 yrs | | DTPa/IPV | | Meningococcal B Vaccine | Dose |
| OTHER | | | | Panadol – Approx. Time given | : |

Notes:

Record of Vaccination Initials_____ Time_____

| | | | |
|---|---|---|---|
| LA / RA Dose # | LA / RA Dose # | LA / RA Dose # | LA / RA Dose # |
| LL / RL | LL / RL | LL / RL | LL / RL |

## Pre-vaccination Screening Checklist

**Please tell the nurse if anything below applies:**

- unwell today

- has or lives with someone with a disease which lowers immunity (eg. leukaemia, cancer, HIV/AIDS) or is having treatment which lowers immunity (eg. oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy) or is pregnant

- has had a severe reaction following any vaccine
- has any severe allergies (to anything)
- has had any vaccine in the past month
- has had an injection of immunoglobulin, or received any blood products or a whole blood transfusion within the past year
- has a past history of Guillain-Barré syndrome
- has a chronic illness
- has a bleeding disorder

Family Members

- planning a pregnancy, anticipating parenthood or had a vaccination during pregnancy
- is a parent, grandparent or carer of a newborn
- has mother received vaccines during pregnancy

**Additional vaccines may be recommended if the person to be vaccinated:**

- identifies as an Aboriginal or Torres Strait Islander
- does not have a functioning spleen
- was born prematurely or had low birth weight under 2kg

**Note: Please ask your nurse questions about this information or any other matter relating to vaccination before the vaccines are given.**

## Consent for Vaccination

**I have read and understood the information given to me about immunisation including the risks and benefits. I have been given the opportunity to discuss this with my nurse. I consent for the named client to be vaccinated with the vaccines ticked. I understand the information I provide, and information related to any vaccines administered, will be recorded electronically and/or in hard copy as a medical record. I consent to the disclosure of this information to staff involved in the provision of an immunisation service for SA Health and local government councils and their immunisation service providers. I acknowledge that the immunisation record will be submitted to the Australian Immunisation Register, where it will be stored on the clients Medicare account.**

**Parent/Legal Guardian Signature** _____ **Date** _____

**Parent/Legal Guardian Name (please print)** _____

*Consent Verified by Registered Nurse -* ***Nurse Initials*** _____