



Consumer Vaccination Pre-Screening/ Consent & Recording Form

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

Full Name		Weight (kg) <small>*Children</small>	
Address			
Email			
Contact Phone Number			
Medicare number	Number before name		
Date of Birth		<input type="checkbox"/> Male	<input type="checkbox"/> Female

2. PRIMARY MEDICAL PRACTITIONER

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. leukemia, 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 ≤ 6 months of age		
<input type="checkbox"/> Have a history of Guillain-Barre syndrome	<input type="checkbox"/> Have ever fainted after having an injection?	

Are you happy to vaccinate outside to reduce infection risk?
Yes / No

4. CONSENT TO RECEIVE Influenza

IMMUNISATION

I have been given, and understand the information provided to me regarding the Influenza 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 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:
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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:	Public Health Unit 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: