Pre-Vaccination Screening Consent Form

PATIENT DETAILS

Name: _____ Date of birth: _____/_____/_____

VACCINATION(S)

I expect to be vaccinated against:

☐ Influenza (influenza vaccine)

Signature: _____

☐ Other vaccines: _____

Signature: _____

at today's visit on:

_____/_____/_____

GENERAL HEALTH AND SUITABILITY FOR VACCINATION

Please tell your vaccinator if you answer yes to any of the following statements, as vaccination may not be suitable for you today.

- You are unwell today ☐ Yes ☐ No
- You have a disease that lowers immunity (eg, leukaemia, cancer, HIV/AIDS) or are having treatment that lowers immunity (eg, oral steroid medicines such as cortisone or prednisolone, radiotherapy, chemotherapy) ☐ Yes ☐ No
- You have had a severe reaction following any vaccine ☐ Yes ☐ No
- You have any severe allergies (to anything) ☐ Yes ☐ No
- You have had any vaccine in the past month ☐ Yes ☐ No
- You have had an injection of immunoglobulin, or have received any blood products or a whole blood transfusion within the past year ☐ Yes ☐ No
- You are pregnant ☐ Yes ☐ No
- You have a history of Guillain-Barré syndrome ☐ Yes ☐ No

Consent form continued next page

Pre-Vaccination Screening Consent Form (continued)

GENERAL HEALTH AND SUITABILITY FOR VACCINATION (continued)

Please tell your vaccinator if you answer yes to any of the following statements, as vaccination may not be suitable for you today.

- You were a preterm infant ☐ Yes ☐ No
- You have a chronic illness ☐ Yes ☐ No
- You have a bleeding disorder ☐ Yes ☐ No
- You are of Aboriginal or Torres Strait Islander descent ☐ Yes ☐ No
- You do not have a functioning spleen ☐ Yes ☐ No
- You are planning a pregnancy or anticipating parenthood ☐ Yes ☐ No
- You are a parent, grandparent, or carer of a newborn. ☐ Yes ☐ No
- You live with someone who has a disease that lowers immunity (eg, leukaemia, cancer, HIV/AIDS), or live with someone who is having treatment that lowers immunity (eg, oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy) ☐ Yes ☐ No
- You are planning travel ☐ Yes ☐ No
- You have an occupation or lifestyle factor(s) for which vaccination may be needed (discuss with vaccinator) ☐ Yes ☐ No

If yes, please specify: _____

CONSENT

- I have been provided with, read, and understood information regarding the possible side effects of each vaccine, and if I have any further questions, I will ask the immuniser prior to being vaccinated.
- I request to have each vaccine(s) nominated overleaf and understand that it is completely voluntary.
- I have been informed of, and agree to pay, the fees or charges associated with this service.
- I agree to remain in the general vicinity of the practice for 15 minutes following vaccination to enable the provision of medical assistance or treatment if required.
- I consent to the provision of emergency care, if required, and authorize the pharmacy or service provider to access medical care on my behalf as required. I understand that I am responsible for any costs associated with any emergency care that may be provided.

Name _____

Signature: _____ Date: ____/____/____

Adapted from the Australian Immunisation Handbook.