Immunisation Consent Form

STAFF (From 20 years)

Office Use Only

☐ Medicare Card Sighted _____

☐ Photo ID Sighted _____

Name: _____ Age: _____

First Name Middle Name Surname

☐ Male ☐ Female Date of Birth: _ _/_ _/_ _ Employee ID # _ _ _ _ _

Address: _____ Suburb: _____ Post Code: _____

☐ Aboriginal ☐ Aboriginal & Torres Strait Islander ☐ Torres Strait Islander ☐ Non Indigenous

Contact Number: _____ Email: _____

Branch Name: _____ Program Leader: _____

Medicare: ☐☐☐☐☐☐☐☐☐☐ Ref No: ☐

Pre-Vaccination Checklist (Please Tick)	YES	NO
1. Are you unwell today?	☐	☐
2. Have you ever had a reaction to any vaccine?	☐	☐
3. Do you have any severe allergies?	☐	☐
4. Have you had a live vaccine (including BCG, MMR, Chickenpox, Rotavirus or Yellow Fever) within the past month?	☐	☐
5. Have you had an injection of Immunoglobulin or Blood Transfusion in the last 12 months?	☐	☐
6. Do you have a disease/condition which lowers immunity, (eg asplenia, leukaemia, cancer, HIV/AIDS, lymphoma, TB, Hodgkin's disease), or receiving a treatment which lowers immunity, (e.g. chemotherapy or radiotherapy)?	☐	☐
7. Do you live with someone who has one of the above diseases or is receiving any of the above treatments?	☐	☐
8. Do you have a chronic illness or bleeding disorder?	☐	☐
9. Do you identify as Aboriginal or Torres Strait Islander (if yes, please circle to identify)	☐	☐
10. Is there any chance you could be pregnant, are breastfeeding or planning pregnancy?	☐	☐
11. Are you planning travel in the next 6 months?	☐	☐
12. Is vaccination a requirement of your PD? If not, do you have permission from your manager to receive vaccinations paid for by Council?	☐	☐
13. Have you had a COVID-19 vaccine? If yes, date received:	☐	☐

Before vaccination, please discuss with the nurse if any of the above conditions apply to the person being vaccinated. The conditions do not necessarily exclude vaccination but should be considered by the nurse giving the vaccine. Every person immunised must wait for a minimum of 15 minutes after immunisation in case of an adverse reaction.

Consent/Authority

- I have read and understood the information page comparing the side effect of vaccines to the effects of the diseases and have had the opportunity to discuss this with the nurses.
- The information completed by me on this form is true and correct to the best of my knowledge.
- I am authorised to request and give consent for vaccination.

Logan City Council is collecting your name, address, contact and, if required, payment details for the purpose of processing your vaccination record. The information will only be accessed by employees and/or Councillors of Logan City Council. The information will be given to The Australian Immunisation Register and accessed by SmartVax (a vaccine safety and surveillance system) Your information will not be given to any other person or agency unless you have given us permission or we are required by law.

By signing this form you agree to be vaccinated by Logan City Council.

Signature:_____ Date:_____

Office Use Only (Nurses, please check, tick and sign)	
☐ Name Checked	☐ Date of Birth Checked
☐ Pre-vaccination checklist reviewed	☐ Risk Factors documented
☐ Confirm Branch	
Nurse Name & Signature:	

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Doc # 12234015

Tick Required Box

Vaccines required	PAID	FREE	LCC Funded	Site	Office Use Only (DOSE- please circle)
☐ **Adacel® or Boostrix®** (Diphtheria, Tetanus, Pertussis)	☐	☐	☐	LA RA	1 2 3
☐ **Bexsero** (Meningococcal B) (2 doses required – 2 months apart)	☐	☐	☐	LA RA	1 2
☐ **Avaxim® or Vaqta®** (Adult Hepatitis A) (2 doses required – 6 months apart)	☐	☐	☐	LA RA	1 2
☐ **EngerixB® or HB Vax II®** (Adult Hepatitis B) (3 doses required @ 0, 1 & 6 months)	☐	☐	☐	LA RA	1 2 3
☐ **Gardasil 9®** (Human Papilloma Virus) (3 doses required @ 0, 2 & 6 months)	☐	☐	☐	LA RA	1 2 3
☐ **Influenza**) **Brand:** _____ (Multiple Brands Available – please specify)	☐	☐	☐	LA RA	1
☐ **IPOL®** (Inactivated Polio) (Primary course: 3 doses required 1 month apart)	☐	☐	☐	LA RA	1 2 3
☐ **Menactra® or Menveo®** (Meningococcal A,C,W,Y	☐	☐	☐	LA RA	1
☐ **Prevenar13** (Pneumococcal) Med @ Risk Refer to NIP Clinical Decision Tree	☐	☐	☐	LA RA	1
☐ **Pneumovax 23®** (Pneumococcal) Med @ Risk Refer to NIP Clinical Decision Tree	☐	☐	☐	LA RA	1
☐ **Priorix® or MMR II®** (Measles, Mumps & Rubella) (Free if born after 1966) (2 doses required @ 1 month apart)	☐	☐	☐	LA RA	1 2
☐ **Twinrix®** (Adult Hepatitis A & B) (3 does required @ 0, 1 & 6 months)	☐	☐	☐	LA RA	1 2 3
☐ **Varivax® or Varilrix®** (Varicella) (2 doses required @ 1 month apart)	☐	☐	☐	LA RA	1 2
☐ **Zostavax®** (Shingles) (Free for those 70-79 years)	☐	☐	☐	LA RA	1

OTHER: _____

NOTES: _____

_____

_____

_____

_____

_____

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The person being vaccinated:

- Was given the opportunity to discuss the risks and benefits of the vaccination. ☐ **Yes**

Nurse Name & Signature:_____ Date: _____

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