Vaccination Pre-Screening/ Consent

Full Name	
Address	
Email	
Phone	
Medicare number	
Date of Birth	

PRE-VACCINATION SCREENING CHECKLIST (reference: Australian Immunisation Handbook online)
Please circle or write to indicate:

Are unwell today	Identify as an Aboriginal or Torres Strait Islander	Have had a severe reaction following any vaccine
Have a chronic illness	Have any severe allergies to anything (anaphylactic)	Have a disease that lowers immunity (e.g. leukaemia, cancer, HIV/AIDS) or are having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy)
Have a bleeding disorder (or take any medications which may increase the risk of bleeding)	Had any blood transfusions in the past year	Do not have a functioning spleen
Are a parent, grandparent or carer of an infant ≤6 months of age	Have a history of Guillain-Barré syndrome	Have ever fainted after having an injection?
Are pregnant or planning pregnancy	Please list below any vaccinations you have received in the last month	

I have been given, and understand the information provided to me regarding the vaccine and possible side effects. If I have further questions, I will ask the immuniser before myself/my child is immunised.

I consent to myself/my child receiving the _____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.

Signature:	Date: