Immunisation Consent Form

Date: _____/_____/_____

PRACTICE DETAILS

Practice: _____

Address: _____

_____

Phone: _____

Fax: _____

PERSON TO BE VACCINATED

Full name: _____

Date of birth: _____

Age: _____

Address: _____

_____

_____

Phone: _____ ☐ Male ☐ Female

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 doctor/nurse. I consent for the above named to be vaccinated with the vaccines ticked below. I understand the vaccination details will be stored and forwarded to the relevant national immunisation registers. I can contact my immunisation service provider if I am concerned personal information has been misused or subject to unauthorised access.

Please tick ☑ appropriate boxes for each vaccine

Adsorbed Diphtheria/Tetanus	☐ YES
Diphtheria/Tetanus/acellular Pertussis	☐ YES
Diphtheria/Tetanus/acellular Pertussis/Polio	☐ YES
Diphtheria/Tetanus/acellular Pertussis/Polio/Hib/Hep B	☐ YES
Hepatitis A	☐ YES
Hepatitis B	☐ YES
Human Papillomavirus (HPV)	☐ YES
Influenza	☐ YES
Measles/Mumps/Rubella	☐ YES
Measles/Mumps/Rubella/Varicella	☐ YES
Meningococcal C conjugate/ *Haemophilus Influenza* type B ……..	☐ YES
Pneumococcal conjugate	☐ YES
Pneumococcal polysaccharide	☐ YES
Polio	☐ YES
Rotavirus	☐ YES
Varicella	☐ YES
Other *(please specify)*……	☐ YES

Signature of person consenting: _____

Print Name: _____ Date: _____

Relationship to person to be vaccinated: _____

Signature of immunisation provider:_____

Print name: _____ Date: _____

For further information on immunisation or the use of personal information, contact your immunisation provider.

Source:
http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/immunisation+for+health+professionals/immunisation+for+health+professionals