

Pre-vaccination screening and consent tool for pharmacist immunisation services

CONSUMER DETAILS		Date:
Name of person to be vaccinated:		
Date of birth:	Age today:	Gender: ☐ Male ☐ Female Other:
Identifies as Aboriginal and/or Torres Strait Islander (TSI): ☐ No ☐ Yes, Aboriginal ☐ Yes, TSI ☐ Yes, both Aboriginal and TSI		
Address:		Phone:
Allergies:		Medicare No:
Name of person completing this form (if different from above):		
Relationship to person to be vaccinated (if completed by someone else):		
NOMINATED PRIMARY HEALTH CARE PROVIDER (if known)		
Name:		
Address:		Phone:
Email:		
VACCINATION(S)		
I or the person to be vaccinated (if applicable), expects to be vaccinated with the following vaccine(s) today (<i>list all</i>):		
Please indicate if you or the person to be vaccinated (<i>if applicable</i>):	Yes	No
Is unwell today (e.g fever). If yes, please specify:	☐	☐
Has a disease that lowers immunity (e.g. leukaemia, cancer, HIV/AIDS) or is having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, DMARDs [disease-modifying anti-rheumatic drugs], radiotherapy, chemotherapy) If yes, please specify:	☐	☐
Has had anaphylaxis or any severe reaction following any vaccine. If yes, please specify:	☐	☐
Has ever fainted after having an injection:	☐	☐
Has a severe allergy to anything. If yes, please specify:	☐	☐
Has had a vaccine in the past month. If yes, please specify:	☐	☐
Has had an injection of immunoglobulin, or received any blood products or a whole-blood transfusion within the past year	☐	☐
Is pregnant	☐	☐

Please indicate if you or the person to be vaccinated (if applicable):	Yes	No
Is planning a pregnancy or anticipating parenthood	☐	☐
Is a parent, grandparent or carer of a newborn	☐	☐
Has a history of Guillain-Barré syndrome (a rare disorder of the nervous system)	☐	☐
Has a chronic illness (e.g diabetes, heart or lung disease). If yes, please specify:	☐	☐
Has a severe illness. If yes, please specify:	☐	☐
Has a bleeding disorder or is taking medications that prevent blood clots	☐	☐
Does not have a functioning spleen	☐	☐
Lives with someone who has a disease that lowers the immunity (e.g leukaemia, cancer, HIV/AIDS) or takes treatment that lowers immunity (e.g. oral steroids, DMARDs [disease-modifying anti-rheumatic drugs], radiotherapy, chemotherapy)	☐	☐
Is planning overseas travel	☐	☐
Has occupational or lifestyle factor(s) where vaccination may be needed. If yes, please specify:	☐	☐

CONSENT/AUTHORITY

I, (Print full name) declare that:

- I have been provided with, read, and understood the information given about immunisation including the risks and benefits, and I have been given the opportunity to ask questions.
- The information completed by me on this form is true and correct to the best of my knowledge.
- I am legally authorised to provide consent on behalf of the person being vaccinated.
- I request to have each vaccine or for the person to be vaccinated to have each vaccine (if applicable) and understand that it is completely voluntary.
- I consent to the immuniser collecting my personal information and that of the person to be vaccinated (if applicable) for the purpose of creating and maintaining a vaccination statement and providing a copy of the vaccination statement, including any such personal information contained in the statement, to the Australian Immunisation Register (AIR) and the nominated primary health care provider.
- I am aware that the immuniser will collect, hold and use my personal information and that of the person to be vaccinated (if applicable) in accordance with relevant privacy laws and its privacy policy, and that I can contact the immuniser at any time for a copy of its privacy policy. I may also contact the immuniser with any concerns I may have about the use of or access to my personal information that it holds.
- I agree to remain within the vicinity of the vaccination service for 15 minutes or for the person to be vaccinated to remain within the vicinity of the vaccination service for 15 minutes (if applicable).
- I have been informed of, and agree to pay, the fees or charges associated with this service.
- I consent to emergency care if required and give permission for the immuniser or pharmacy staff to access medical care on my behalf or on behalf of the person to be vaccinated (if applicable). I understand that I am responsible for any costs associated with any emergency care.

Signature of person consenting:

Date:

Name of person consenting:

Relationship to person to be vaccinated (if applicable):

Parent ☐ Legal guardian ☐

Authorised immuniser:

Physical location (e.g. location of pharmacy or vaccination premises where vaccine is administered):

Pharmacy Stamp (if applicable):