The Pharmacy Guild of Australia

# Consumer Vaccination Pre-Screening/ Consent & Recording Form

| Pharmacy details: | Unique reference number: |
|---|---|

## 1. PERSONAL DETAILS (PERSON TO BE VACCINATED)

| | | | |
|---|---|---|---|
| Full Name | | | |
| Address | | | |
| Email | | | |
| Contact Phone Number | | | |
| Medicare number | | | |
| Date of Birth | | | ❑ Male ❑ Female |

## 2. PRIMARY MEDICAL PRACTITIONER (OPTIONAL)

| | | | |
|---|---|---|---|
| Doctor | | Phone | |
| Address | | | |
| Email | | | |

## 3. PRE-VACCINATION SCREENING CHECKLIST *(reference: Australian Immunisation Handbook online)*

Please indicate if you/ your child (the person to be vaccinated today):

| | | |
|---|---|---|
| ❑ Are unwell today | ❑ Identify as an Aboriginal or Torres Strait Islander | ❑ Have had a severe reaction following any vaccine |
| ❑ Have a chronic illness | ❑ Are pregnant or planning pregnancy | ❑ 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 | ❑ Please list below any vaccinations you have received in the last month |
| | ❑ 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? | |

## 4. CONSENT TO RECEIVE _____ IMMUNISATION

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.

I consent to a copy of my Statement of Immunisation being provided to my nominated medical practitioner
❑ Yes ❑ No

| Signature: | Name: | Date: |
|---|---|---|

| RECORD OF_____IMMUNISATION<br>*(Immuniser use only)* | | |
|---|---|---|
| Date: | Time: | |
| Vaccine<br>Brand: | Injection Site:<br>❑ Left arm<br>❑ Right arm | Batch<br>number:<br>Expiry date: |
| Adverse event experienced (if any): | Treatment given: | WAVVS notified of adverse event.<br>❑ Yes ❑ No |
| Pre/post vaccination counselling<br>❑ Yes ❑ No | Notes: | |
| Statement of immunisation given<br>❑ Yes ❑ No | Doctor notified (fax/email/phone)<br>❑ Yes ❑ No | Doctor details: |
| Signature: | Date: | Accreditation Number: |