

• I M M U N I S A T I O N C O N S E N T F O R M •



Government of South Australia
SA Health

Please read the immunisation information provided and discuss with the medical practitioner or registered nurse before completing this consent form.

VACCINEE'S family name: _____ First name: _____

Address: _____ Postcode: _____

Telephone: _____ Date of Birth: ____ / ____ / ____ Male Female

I have read and understood the information given to me about immunisation including the risk of the vaccination and the risk of not being vaccinated. I have been given the opportunity to discuss the risks and benefits with my doctor/nurse. I consent for the above named to be vaccinated with the vaccines as indicated.

Please tick appropriate boxes and sign for each vaccine

Signature

- Hepatitis B..... YES _____
- Diphtheria/Tetanus/acellular Pertussis/Polio/Hib/Hep B (Infanrix Hexa) YES _____
- Pneumococcal conjugate (Prevenar 13) YES _____
- Rotavirus..... YES _____
- Measles/Mumps/Rubella (Priorix)..... YES _____
- Meningococcal C conjugate (NeisVac-C)..... YES _____
- Haemophilus Influenzae* type B (Hiberix) YES _____
- Varicella (Chickenpox vaccine)..... YES _____
- Hepatitis A..... YES _____
- Diphtheria/Tetanus/acellular Pertussis/Polio (Infanrix/IPV)..... YES _____
- Diphtheria/Tetanus/acellular Pertussis (Adolescent/Adult dTpa) YES _____
- Human Papillomavirus (HPV) YES _____
- Adsorbed Diphtheria/Tetanus (ADT Booster) YES _____
- Polio (IPV)..... YES _____
- Influenza YES _____
- Pneumococcal polysaccharide (Pneumovax 23)..... YES _____
- Other (*specify*) _____ YES _____
- Other (*specify*) _____ YES _____
- Other (*specify*) _____ YES _____

Please complete if you have given consent:

Print name: _____

Relationship to person being vaccinated: _____ Date: ____ / ____ / ____

Witness/provider name: _____ Signature: _____ Date: __ / __ / __

Name of Immunisation Clinic/Practice/Doctor: _____

Signed form to be stored in clinical records

Last reviewed August 2011