CONSUMER VACCINATION PRE-SCREENING/ CONSENT & RECORDING FORM

1. PERSONAL DETAILS (PERSON TO BE VACCINATED)

First Name:	Surname:	
Address:		Post Code:
Phone Number:	Email:	
Date of Birth:	Employer/Organisation:	
Medicare number:	Position on card:	Exp:

2. PRE-VACCINATION SCREENING CHECKLIST

Please tick "yes" or "no" if you/ your child (the person to be vaccinated today):

Question	Yes	No
Are unwell today		
Have a chronic illness		
Have a disease that lowers immunity (eg leukemia, cancer, HIV/AIDS) or are having treatment that lowers immunity (eg oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy)		
Have a history of Guillain-Barre syndrome		
Have any severe allergies to anything (anaphylactic) including medicines and/or food (egg, gelatine)		
Have any bleeding disorders (or take any medications which may increase the risk of bleeding)		
Do not have a functioning spleen		
Have ever fainted after having an injection		
Have had a severe reaction following any vaccine		
Are pregnant or planning pregnancy		
Had any blood transfusions in the past year or immunoglobulin		
Please list any vaccines you have received in the last 14 days (eg COVID-19) ➔ ……		

3. 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 I am immunised. The flu vaccine is very safe and generally people have no reaction. The most common side effects are tenderness, swelling and redness at the injection site which usually disappears within a few days. A small percentage of people may experience a mild fever and feel unwell for a few days – this is not the flu. These symptoms clear up within a few days.

I understand I must remain within the designated nearby area for a period of 15 minutes after vaccination for observation and so that I may receive additional medical attention, including emergency care, if needed.

I consent to receiving the influenza vaccine and reporting my vaccine to the Australian Immunisation Register.

Signature:	Date:
	Name:

RECORD OF INFLUENZA IMMUNISATION (Nurse Immuniser use only)

Nurse Immuniser Name:

Signature:

Vaccine Batch No:

Expiry Date:

Date: