IPSWICH CITY COUNCIL

Immunisation Consent Form

VSP Number: WM 5002	Clinic		Date of Vaccination	

CHILD/PATIENT DETAILS

Title		Given names		Surname	
Date of birth	☐☐ / ☐☐ / ☐☐☐☐			Gender	☐ Male ☐ Female
Property address					
Suburb				State/Territory		Postcode	
Home phone				Mobile	
Medicare number	☐☐☐☐☐☐☐☐☐☐			Ref number		Valid to date	
Is the patient Aboriginal/Torres Strait Islander?				☐ Yes ☐ No	
Was the child born less than 32 weeks gestation (weeks of pregnancy)?				☐ Yes ☐ No	
How many weeks				Weight at birth	
Is the patient diagnosed as medically at risk? *(Ask nurses for definition) If yes, Medical Condition*					

OFFICE USE ONLY

Vaccine	Code	Dose	Batch Number	Comments
Infanrix Hexa/Vaxelis	IFHX/VAXLIS	☐ 1st ☐ 2nd ☐ 3rd		
Rotarix	RRIX	☐ 1st ☐ 2nd		
Men B 2 months	BEXO	☐ 1st ☐ 2nd ☐ 3rd		
Prevenar	PRE	☐ 1st ☐ 2nd ☐ 3rd ☐ 4th		
MMR 11/Priorix	MMR/PRI	☐ 1st		
Nimenrix Men ACWY	NIMR	☐ 1st		
HIB	HIB	☐ 4th		
Priorix-Tetra/Proquad	PRXT/PROQ	☐ 2nd		
Infanrix/Tripacel	INFX/TCL	☐ 4th		
Hep A	HAVQ	☐ 1st ☐ 2nd		
dTpa-IPV/Quadracel	IFIP/QDCL	☐ 1st ☐ 2nd ☐ 3rd ☐ 5th		
Pneumovax	PNE	☐ 1st		
Other – Pregnant women / Over 65s / Flu / Catch up school / Catch up				
dTpa (Boostrix)/Adacel	BRIX/ADCL	☐ 1st		
Gardasil	HPV	☐ 1st		
Men ACWY	NIMR	☐ 1st		
Men B	BEXO	☐ 1st ☐ 2nd		
		☐		
		☐		

Ipswich City Council is collecting your personal information so that we can assess your details for our vaccination/immunisation program. We will not disclose your personal information outside of Council unless we are required by law ot you have given your consent. However, in order to perform the above functions, we may need to disclose your personal information to Queensland Health, Australian Childhood Immunisation Register or medical practitioners. By completing and signing this form and returning it to Council, we will consider that you have given us your consent to manage your personal information in the manner described in Council's Privacy Statement, Information Digest and this collection notice.

City of Ipswich

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Pre-Vaccination Checklist

The following information is needed to assess the fitness of a person for vaccination. Please tick any of the boxes that may apply to the person to be vaccinated. Answering YES to any of the conditions listed below does not necessarily mean that you/child/patient cannot be vaccinated today. The clinic staff are happy to discuss any questions you may have.

THE PERSON TO BE VACCINATED		
Is unwell today (ATTN: a mild illness such as the common cold with a temperature less than 38.5°C should not exclude a patient from receiving a vaccination)?		☐ Yes ☐ No
Please describe		
Has a disease which lowers immunity (e.g. leukamemia, cancer, HIV/AIDS or is having treatment which lowers immunity (e.g. steroid medicines, radiotherapy, chemotherapy))?		☐ Yes ☐ No
Please describe		
Lives with someone who has a disease which lowers immunity, or lives with someone who is having treatment which lowers immunity?		☐ Yes ☐ No
Is taking any medications, injections or supplements?		☐ Yes ☐ No
Please describe		
Has had a severe reaction following any vaccine?		☐ Yes ☐ No
Please describe		
Has any severe allergies to anything (an allergy must be recorded)?		☐ Yes ☐ No
Please describe		
Has had a chronic illness or bleeding disorder?		☐ Yes ☐ No
Please describe		
Has had any vaccine within the last month, or an injection of immunoglobulin, or received any blood products or a whole blood transfusion within the past year?		☐ Yes ☐ No
Is pregnant?		☐ Yes ☐ No
Is living with someone who is not vaccinated?		☐ Yes ☐ No
Has a past history of Guillain-Barre syndrome?		☐ Yes ☐ No

I have read and understood the information provided regarding the benefits and possible side effects of the vaccine/s.
I acknowledge that the vaccination details will also be forwarded to Queensland Health and recorded on a relevant National database. I hereby give consent for myself/patient/child to be immunised.

Relationship to patient	☐ Parent ☐ Legal guardian ☐ Authorised person (attach Authority to Care)				
Title		Given names		Surname	
Property address					
Suburb		State/Territory		Postcode	
Signature				Date	

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Immunisation Clinic

VACCINES ON THE NATIONAL IMMUNISATION PROGRAM

VACCINE	ADDITIONAL POSSIBLE REACTIONS TO VACCINE	GIVEN	SITE
dTpa – Hep B – Polio – Hib Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio Haemophilus influenzae Type B	See over for reactions	☐	LA RA LL RL
Pneumococcal vaccines 13vPCV (and 23vPPV)	See over for reactions	☐	LA RA LL RL
Rotavirus	May develop vomiting and diarrhoea up to 7 days after vaccination	☐	ORAL
Measles/Mumps/Rubella (MMR) Measles/Mumps/Rubella/ Varicella (MMRV) Varicella/Chicken Pox (VZV)	**Seen 5 to 12 days after vaccination** ▪ Low grade fever lasting 2-3 days ▪ Head cold and/or runny nose, cough and/or puffy eyes ▪ Faint red rash (which is not infectious) ▪ Cold like symptoms, runny nose, cough ▪ Swelling of salivary glands **Varicella/Chicken Pox (VZV)** ▪ 5-26 days after vaccination ▪ Few small red lumps or blisters (2-5 lesions) usually at injection site which occasionally covers other parts of the body (mild infection)	☐	LA RA
Meningococcal ACWY (Men ACWY)	▪ Loss of appetite ▪ Headache	☐	LA RA LL RL
Meningococcal B (Men B) Queensland Health recommends paracetamol be given to children aged <2 years with each does of Bexsero®.	▪ Loss of appetite ▪ Headache ▪ High risk of elevated fever ▪ Queensland Health recommends giving three doses of paracetamol with each dose of the vaccine as follows: • Dose 1 - 30 minutes before vaccination or as soon as possible afterwards • Dose 2 - given six hours after the first paracetamol dose (even if there is no fever) • Dose 3 - given six hours after the second paracetamol dose (even if there is no fever)		
dTpa – Diphtheria, Tetanus, Pertussis dTpa-IPV – Diphtheria, Tetanus, Pertussis, Polio	See over for reactions	☐	LA RA LL RL
Haemophilus influenzae Type B	See over for reactions	☐	LL RL
Hepatitis A (Hep A) Hepatitis B (Hep B)	See over for reactions	☐	LA RA LL RL
Influenza	See below for reactions	☐	LA RA

LA = Left Arm, LL = Left Leg, RA = Right Arm, RL = Right Leg

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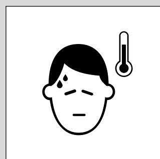
SCHOOL-BASED VACCINES

VACCINE	ADDITIONAL POSSIBLE REACTIONS TO VACCINE	GIVEN	SITE
Human papillomavirus (HPV)	▪ Mild nausea ▪ Mild headache	☐	LA ☐☐ RA
Meningococcal ACWY (Men ACWY) Meningococcal B (Men B)	▪ Loss of Appetite ▪ Headache	☐	LA ☐☐ RA
Diphtheria, Tetanus, Pertussis containing vaccines (dTpa) Teenager/adult	See below for reactions	☐	LA ☐☐ RA

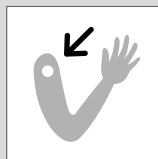
LA = Left Arm, LL = Left Leg, RA = Right Arm, RL = Right Leg

IMMUNISATION – WHAT CAN HAPPEN AFTER VACCINATION AND WHAT TO DO

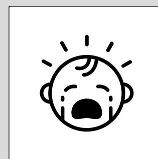
ALL VACCINATIONS MAY CAUSE THE FOLLOWING REACTIONS



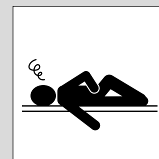
Mild fever that doesn't last long <38.5°C



Where the needle was given: sore, red, burning, itching, or swelling for 1-2 days and/or small, hard lump for a few weeks



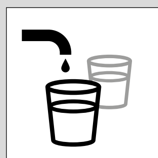
Grizzly, unsettled, unhappy and sleepy



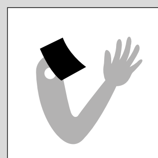
Teenagers/ adults fainting and muscle aches

WHAT TO DO AT HOME

If baby/child is hot don't have too many clothes or blankets on



Breastfeed more frequently and/or give extra fluids



Put a cold wet cloth on the injection site if it is sore

For fever or pain give paracetamol (e.g. Panadol®) according to age as directed on the bottle or packet

WHEN TO SEEK MEDICAL ADVICE

If pain and fever are not relieved by paracetamol (e.g. Panadol®)

If the reactions are not going away or getting worse, or if you are worried at all, call 13HEALTH, see your doctor, or go to hospital

WAIT 15 MINUTES FOLLOWING IMMUNISATION.
CALL 13HEALTH IF CONCERNED.

Source: The Australian Immunisation Handbook 10th Edition 2013

Last reviewed April 2024_A5460013