



APPLICATION FOR IMMUNISATION

CHILDHOOD VACCINES

YES, I have read and understood the information given to me about immunisation, including the risk of vaccination and the risk of not being vaccinated. I have been given opportunity to discuss the risk and benefits with my nurse. I request to be immunised with the vaccines recommended in the immunisation schedule, as indicated. I understand that consent can be withdrawn at any time.

FULL NAME (please print in BLOCK LETTERS):

MEDICARE NO: **INDIVIDUAL NUMBER ON CARD**

DATE OF BIRTH: **Male** ☐ **Female** ☐ **Other** ☐

ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN? ☐ **YES** ☐ **NO**

ADDRESS: **SUBURB:**

POSTCODE: **PHONE NUMBER:**

PARENT'S/CARER'S NAME: **SIGNATURE:**
(Please print)

DATE:

OFFICE USE ONLY

AGE VACCINES GIVEN

6 weeks - 2mths ☐ **IFX/HEXA** ☐ **PV20** ☐ **Rotarix** ☐ **Bexsero**

4mths ☐ **IFX/HEXA** ☐ **PV20** ☐ **Rotarix** ☐ **Bexsero**

6mths ☐ **IFX/HEXA**

12mths ☐ **Nimenrix (Men ACWY)** ☐ **PRX or MMRII**
☐ **PV20** ☐ **Bexsero**

18mths ☐ **Act-HIB (Haemophilus Influenzae B Hib)**
☐ **Tripacel OR IFX (Diphtheria Tetanus Pertussis)**
☐ **Priorix Tetra OR ProQuad (MMR +Varicella)**

4 years ☐ **IFX/IPV or Quadracel (dTp + Polio)**

6mths - < 5 years ☐ **Flu**