



APPLICATION FOR IMMUNISATION

SCHOOL 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 I understand that consent can be withdrawn at any time.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**

ALLERGIES: ☐ **YES** ☐ **NO** **Specify:**

ADDRESS: **SUBURB:**

POSTCODE: **PHONE NUMBER:**

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

DATE:

OFFICE USE ONLY

VACCINES GIVEN

YEAR 7

Human Papilloma Virus ☐

Diphtheria, Tetanus, Whooping Cough ☐

YEAR 10

Meningococcal B ☐ Dose 1 ☐ Dose 2

Meningococcal ACWY ☐