Pre-vaccination Checklist

Given Name/s: _______________Surname: _______________ Date of Birth: /   /

Please carefully read the following and circle the applicable answer. If you are unsure about any of the following, or have any questions regarding the vaccines ask your GP or practice nurse before being immunised.

The person to be vaccinated:

Is unwell today	Yes / No
Has a disease which lowers immunity (e.g. leukaemia, cancer, HIV/AIDS) or is having treatment which lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy)	Yes / No
Lives with someone who has a disease which lowers immunity. Or lives with someone who is having treatment which lowers immunity	Yes / No
Has had a severe reaction following any vaccine	Yes / No
Has *any* severe allergies (to anything)	Yes / No
Has had a live virus vaccine within the last month (this includes measles-mumps-rubella vaccine, oral poliomyelitis vaccine, varicella (chickenpox) vaccine and yellow fever vaccine)	Yes / No
Has had an injection of immunoglobulin, or a whole blood transfusion within the last three months	Yes / No
Has a bleeding disorder or problem with spleen	Yes / No
Has a past history of Guillain-Barre syndrome	
Identifies as an Aboriginal or Torrens Straight Islander person	

I have read and understood the information given to me about the Immunisation/s including the risk of vaccination and also the risk of not being vaccinated. I have been given the opportunity to discuss the risks and benefits with my Dr / Nurse. I understand that consent can be withdrawn at any time.

Parent/Guardian Signature: ____

STAFF USE

NURSES:	Affix label here	Affix label here	Affix label here	Affix label here	Affix label here
DR:	LA RA LL RL	LA RA LL RL	LA RA LL RL	LA RA LL RL	ORAL