The Pharmacy Guild of Australia

Consumer Vaccination Pre-Screening/ Consent & Recording Form

Pharmacy details:	CARLTON RAILWAY PHARMACY W. Hijazi & D. Abi-Hanna 34 - 36 Carlton Pde, Carlton 2218 Ph: **9587 5515** Fax: **9588 6272**	Unique reference number:

1. PERSONAL DETAILS

Full Name					
Address					
Contact Phone Number		**Medicare no.**		**Expiry**	
Date of Birth		Sex	❑ Male	❑ Female	

2. PRIMARY MEDICAL PRACTITIONER

Doctor		Phone	
Address			
Email			

3. PRE-VACCINATION SCREENING CHECKLIST *(reference: Australian Immunisation Handbook 10th ed)*

Please indicate if you:

❑ Are unwell today	❑ Identify as an Aboriginal or Torres Strait Islander	❑ Have had a severe reaction following any vaccine
❑ Have a past history of Guillain-Barré syndrome	❑ Are pregnant	❑ Have *any* severe allergies to anything (anaphylactic)
❑ Have a disease that lowers immunity (e.g. leukaemia, cancer, HIV/AIDS) or are having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy)	❑ Have a chronic illness ❑ Have ever fainted after having an injection? ❑ Have a bleeding disorder or take any medications which may increase the risk of bleeding	❑ Please list any vaccinations or blood products you have received and the date administered.

4. CONSENT TO RECEIVE ___ **INFLUENZA** ___ IMMUNISATION

I have been given, and understand the information provided to me regarding the ___ **influenza** ___ vaccine and possible side effects. If I have further questions, I will ask the immuniser before I am immunised. I consent to receiving the ___ **influenza** ___ vaccine. I understand I must remain within the pharmacy premises for a period of 15 minutes post vaccination for observation and so that I may receive additional medical attention, including emergency care, if needed. I have been advised of, and agree to pay the charges associated with this service.

I understand that this service will be recorded on the Australian Immunisation Register.

I consent to a copy of my Statement of Immunisation being provided to my nominated medical practitioner ❑ Yes ❑ No

Signature:	Name:	Date:

RECORD OF ___ **INFLUENZA** ___ IMMUNISATION *(Immuniser use*		
Vaccine Brand:	Injection Site: ❑ Left arm deltoid ❑ Right arm deltoid	Batch number:
Adverse event experienced (if any): Treatment given:		Public Health Unit notified of adverse event. ❑ Yes ❑ No
Pre/post vaccination counselling ❑ Yes ❑ No	Notes:	
Statement of immunisation given ❑ Yes ❑ No	Signature:	Date:
Doctor notified (fax/email/phone) ❑ Yes ❑ No	Name:	Accreditation Number: