Day Night Chemist Crows Nest

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Crows Nest
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Pre-Flu Immunisation Screening and Consent

Consumer Details

Name:

Mobile Number:

Email:

Address:

Allergies:

Date of Birth:

Medicare Number:

Medicare Expiry Date:

Voucher No:

Primary Healthcare Provider

Name:

Address:

Phone:

Email:

General Health and Suitability for Vaccination

Please tell your nurse, doctor or pharmacist if you answer **yes** to any of the following statements as vaccination may not be suitable for you today.

- ☐ Yes ☐ No You are unwell today
- ☐ Yes ☐ No You have a disease that lowers immunity (e.g. leukemia, cancer, HIV/AIDS) or having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone or prednisolone, radiotherapy or chemotherapy)
- ☐ Yes ☐ No You have severe allergies (to anything)
- ☐ Yes ☐ No You have had a severe reaction following any vaccine
- ☐ Yes ☐ No Have you received any other vaccination in the last 7 days?
- ☐ Yes ☐ No You have had an injection of immunoglobulin, or have received any blood products or a whole blood transfusion within the past year
- ☐ Yes ☐ No You are pregnant
- ☐ Yes ☐ No You are planning pregnancy or anticipating parenthood
- ☐ Yes ☐ No You have a history of Guillain - Barre syndrome
- ☐ Yes ☐ No You were a pre-term infant
- ☐ Yes ☐ No You have a chronic illness
- ☐ Yes ☐ No You have a bleeding disorder
- ☐ Yes ☐ No You are of Aboriginal or Torres Strait Islander descent
- ☐ Yes ☐ No You do not have a functioning spleen

☐ Yes ☐ No You are a parent, grandparent or a carer of a newborn

☐ Yes ☐ No You live with someone who has a disease that lowers immunity (e.g. leukemia, cancer, HIV/AIDS) or live with someone who is having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone or prednisolone, radiotherapy or chemotherapy)

☐ Yes ☐ No You are planning travel

☐ Yes ☐ No You have an occupation or lifestyle factor(s) for which vaccination may be needed (discuss with doctor/pharmacist/nurse). Please Specify:

Pharmacist Notes

Consent

- I have been provided with, read and understood information regarding the possible side effects of each vaccine, and if I have further questions, I will ask the immuniser prior to being vaccinated.
- I understand that if my health insurer or employer is paying for this service, your name may be disclosed for the purposes of verification, payment and invoicing. Personal health information provided in the pre-screening form or discussed with your pharmacist will not be disclosed to any party.
- I understand and agree to stay in the pharmacy for a 15 minute period post the vaccination.
- I request to have each vaccine and understand that it is completely voluntary.
- I have been informed of, and agree to pay the fees

☐ I would like a record of my vaccination, available through the pharmacy App. You will receive a text message with registration link. Please confirm your mobile number: _____

Name of patient (or parent/guardian of child): _____

Signature of patient (or parent/guardian of child): _____

Date: _____