

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: _____

The Pre-Flu Immunisation Screening and Consent form ("The Document") has been developed in electronic format by MedAdvisor International Pty Ltd ("MedAdvisor") based on the Practice guidelines for the provision of immunisation services within pharmacy (Dec 2014) developed by the Pharmaceutical Society of Australia (the guidelines) and the Australian Immunisation Handbook (June 2015) developed by the Australian government, Department of Health (the guidelines). The Document must be used in accordance with the guidelines and other relevant industry standards, codes, regulations and laws. Consistent with the guidelines pharmacists must exercise professional judgement in using the Document, this may include adapting it to better address specific presenting circumstances. MedAdvisor accepts no liability for any loss with any person that may suffer as a result of reliance on the Document or any information contained therein.