

Adult Pre-vaccination Screening Checklist and Consent Form

This checklist helps your doctor and nurse make decisions about vaccinating you. Please answer the following questions and advise your immunisation provider if any of the following apply:

	Yes	No
1. Are unwell today?		
2. Have had a severe reaction following any vaccine?		
3. Have you had any severe allergies to anything, especially antibiotics, eggs, latex rubber?		
4. Do you have a disease that lowers immunity eg: cancer, leukaemia, HIV?		
5. Are you having treatment that lowers immunity eg: radiation, chemotherapy, steroid medicines such as cortisone and prednisone?		
6. Are you living with someone who has a disease that lowers immunity or having treatment that lowers immunity?		
7. Do you have a chronic disease such as diabetes, heart disease, asthma, epilepsy?		
8. Have you had a vaccine containing live viruses within the last month such as MMR, yellow fever or an injection of immunoglobulin or a blood transfusion within the past year?		
9. Are you Pregnant?		
10. Do you have a history of Guillain-Barre' Syndrome?		
11. Do you have a functioning spleen?		
12. Do you have a bleeding disorder?		
13. Do you identify as Aboriginal or Torres Strait Islander?		
14. Do you consent to Smartvax sending an SMS message in 3 days to monitor for any reaction to the vaccination/s?		

PLEASE NOTE: If you have questions about the above information or any matter relating to immunisation please ask your GP or nurse prior to the vaccination being given.

VACCINE	BATCH #	SITE		GIVEN BY	REMINDER	ENTERED BY
		RA	LA			
		RA	LA			
		RA	LA			

I understand the possible reactions and give consent to the immunisation including the information being sent to the Australian Immunisation Register (AIR).

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

OFFICE USE ONLY

Nurses Name and Signature: _____