



CHANCELLOR PARK
FAMILY MEDICAL PRACTICE

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CONSENT FOR IMMUNISATIONS FORM

Patient Surname: _____ **Patient Address:** _____
Patient Given Names: _____
Patient D.O.B _____
Doctor Requesting Consent: _____
Patient/ Parent/ Guardian Giving Consent: _____

A) Vaccination not only protects individuals, but also others in the community, by increasing the general level of immunity and minimising the spread of infection. As a result of successful vaccination programs, deaths from Tetanus, Diphtheria, Haemophilus Influenza Type B and Measles are now extremely rare in Australia.

B) Risks of Vaccinations:

It is recommended that the patient remain in the Treatment Room for at least 15 minutes following vaccination, to observe they do not have any immediate adverse reactions, eg. 'Anaphylaxis' which is extremely rare.

Rare, late events shown to be casually related to some Vaccines are:

One in one million doses of MMR Vaccine causes acute encephalitis 8 – 9 days after vaccination. In comparison, between one in one thousand cases of measles result in severe acute encephalitis with a ten percent mortality and considerable morbidity rate.

Vaccines containing Diphtheria and Tetanus have been described as causing brachial neuritis (inflammation of a nerve in the arm), with an incidence of approximately one in one thousand adults.

C) Acknowledgements:

1) The Patient/ Parent/ Guardian:

I acknowledge that the Doctor and Nurse have provided me with information concerning the immunisations that will be given to myself/ my child today. Also they have answered any specific queries or concerns I have regarding these immunisations.

I have read the "Pre Vaccination Checklist" and told the Doctor/Nurse if any of this applies to me. I have also been given and had explained to me the "Post Vaccination Parent Advice Sheet" for parents and guardians

Signature of Patient/ Parent/ Guardian: _____ **Date:** _____

2) The Doctor:

I declare that I have personally explained why we give vaccinations and I have confirmed the patient healthy and afebrile today.

I have given the patient/ parent/ guardian named above an opportunity to ask questions, which I have answered as fully as possible.

Signature of Doctor: _____ **Date:** _____

THIS SECTION TO BE COMPLETED BY NURSE ONLY

3) The Nurse:

I declare that I have personally explained the present Immunisation Schedule and which immunisations are to be given today. I have given and explained to the patient/ parent/ guardian the Post Vaccination Parent Advice Sheet as well as giving them an opportunity to ask any questions, which I have answered to the best of my ability.

Signature of Nurse giving vaccinations: _____ **Name of Nurse:** _____ **Date:** _____

Immunisations Given:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Polio | <input type="checkbox"/> Hib | <input type="checkbox"/> Pneumococcal |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Measles, Mumps and Rubella | |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Meningitis C | |