Varela & Swift PHARMACY

The Pharmacy Guild of Australia

Consumer Vaccination Pre-Screening/ Consent & Recording Form

Pharmacy details: Varela & Swift Pharmacy, 80 Main St, Murwillumbah (02)66722388	Unique reference number:

1. PERSONAL DETAILS

Full Name			
Address			
Contact Phone Number			
Date of Birth		Sex	❑ Male ❑ Female

Email:

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 e.g. egg allergy)
❑ 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 (warfarin or other anticoagulants)

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

Signature:	Name:	Date:

RECORD OF ______ IMMUNISATION *(Immuniser use only)*		
Vaccine: Brand:	Injection Site: ❑ Left arm deltoid ❑ Right arm deltoid	Batch number: Expiry date:
Adverse event experienced (if any): Treatment given:		Public Health Unit notified of adverse event. Phone: 1300 066 055 ❑ 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: