



CITY OF  
**Port Adelaide Enfield**

# Application Form Childhood Immunisation

Child's Surname  First Name(s)

Address

Suburb  Postcode

Phone number  Mobile Number

Date of Birth  Gender Male  Female

Do you have a Medicare card? Yes  No  Medicare No.  Ref. No. on Card

**YES**, I have read and understood the information given to me about immunisation, including the risk of the vaccination and the risk of not being vaccinated. I have been given the opportunity to discuss the risk and benefits with my nurse. I request my child to be immunised with the vaccines recommended in the immunisation schedule for pre-school aged children, as indicated. I understand that consent can be withdrawn at any time. I give permission for the Council to access my child's details on the Australian Childhood Immunisation Register for obtaining a history of previous vaccinations in order to update Council's records.

Signature  Date

Name (please print)  Relationship to child

Do you identify as Indigenous or Torres Strait Islander descent? Yes  No

## Port Adelaide Enfield Office Use Only

Vaccine		Age			Batch No
		2 mths	4 mths	6 mths	
Pneumococcal conjugate (Prevenar)	<b>PV</b>	2 mths	4 mths	6 mths	
Diphtheria/Tetanus/Pertussis Haemophilis Influenzae type B, Hep B/IPV	<b>IFX HEXA</b>	2 mths	4 mths	6 mths	
Rotavirus	<b>RVV</b>	2 mths	4 mths	6 mths	
Hib (Hiberix)	<b>HBX</b>	12 mths			
Meningococcal conjugate C (Neisvac C or Meninigtec)	<b>NVC</b>	12 mths			
Measles Mumps Rubella (Priorix)	<b>PRX</b>	12 mths	4 years		
Diphtheria/Tetanus/Pertussis/IPV (Infanrix/IPV)	<b>IFX IPV</b>		4 years		
Varicella (Chicken pox vaccine) (Varilrix or Varivax)	<b>VV</b>	18 mths	School Year 8 (comm. 2006)		
Diphtheria/Tetanus/Pertussis (Boostrix)	<b>DTPA</b>	School Year 9			
Hepatitis B (H-B-Vax11) Adult	<b>HBVA</b>	School Year 8			
Hepatitis B (H-B-Vax11) Paediatric	<b>HBVP</b>				
Hepatitis A (Indigenous)	<b>HAP</b>	18 mths	2 years		
Pneumococcal (Indigenous)	<b>PN</b>	2 years			
Human Papilloma Virus	<b>HPV</b>				

## Immunisation History

Birthdose	2 mths	4 mths	6 mths	12 mths	18 mths

## Payment Details

Invoice Yes  No  Amount \$  Visa MasterCard Bankcard

Credit Card No.  Expiry Date