



IMMUNISATION REGISTRATION

CHILD'S DETAILS

Family Name:	<input type="text"/>	Given Names:	<input type="text"/>
Date of Birth:	<input type="text"/>	Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Address	<input type="text"/>		
	<small>Street address</small>	<small>Suburb</small>	<small>Postcode</small>
Medicare Card Number:	<input type="text"/>	Child Medicare Reference no:	<input type="text" value="1 / 2 / 3 / 4 / 5 / 6"/>

PARENT/GUARDIAN'S DETAILS

Family Name:	<input type="text"/>	Given Name:	<input type="text"/>
Relationship to Child:	<input type="text"/>	Please circle:	Mr / Mrs / Ms / Other _____
Home Phone:	<input type="text"/>	Alternate Phone:	<input type="text"/> Mobile / Work
Emergency Contact Name:	<input type="text"/>	Emergency Contact Phone:	<input type="text"/> Mobile / Work

I, _____ (parent/guardian name) having read
(please print)
and understood the information on the risks and benefits of vaccination, do hereby give consent for the child,
 _____ (name) to be vaccinated with the vaccines as indicated on
(please print) **the N.I.P. Schedule.**
Signature: _____ **Date:** ____/____/____

Either fax, post or bring the completed form to the next immunisation clinic
 Fax: 9936 8177 Post: North Sydney Council, PO Box 12, North Sydney 2059
 For further information contact the Immunisation Co-ordinator on (02) 9936 8100.

Health Records and Information Privacy (HRIP) Act
 In completing this form you will be prompted to supply information that is personal information for the purposes of the Health Records and Information Privacy (HRIP) Act, 2002. The supply of this information is voluntary. If you cannot provide, or do not wish to provide the information sought, North Sydney Council may be unable to process your request. Council is required under the Act to inform you about how your personal information is being collected and used. If you require further information please contact Council's Customer Service Centre on (02) 9936 8100 and ask for an information sheet to be sent to you.

INTERPRETER REQUIRED? YES NO LANGUAGE: _____
 ABORIGINE OR TORRES STRAIT ISLANDER? YES NO

Record of immunisation history on page overleaf to be filled in by immunisation clinic co-ordinator at first clinic



IMMUNISATION DETAILS

OFFICE USE ONLY: Details of Immunisations Administered

KEY DETAILS

Child's Name:

Date of Birth:

Medicare Card Number:

Child Medicare Reference no:

Vaccine (diseases listed)	Dose 1		Dose 2		Dose 3	
	Date given	Consent (or provider details)	Date given	Consent (or provider details)	Date given	Consent (or provider details)
Hepatitis B (at birth)						
Infanrix Hexa						
- Diphtheria, Tetanus, Pertussis						
- Haemophilus influenzae type B (Hib)						
- Hepatitis B						
- Polio						
Prevenar (Pneumococcal)						
Rotarix (oral) (Rotavirus)						
Priorix (Measles, Mumps, Rubella)						
Hiberix (Hib)						
Meningitec (Meningococcal C)						
Varilrix (Varicella – Chicken Pox)						
Infanrix-IPV						
- Diphtheria, Tetanus, Pertussis						
- Polio						
Other						
Other						
Other						
Other						
Other						
Other						
Other						