SOUTH WANGARATTA MEDICAL CENTRE

IMMUNISATION DOCUMENTATION CATCH UP SERVICE REGISTRATION FORM

PATIENT INFORMATION *(PLEASE PRINT IN CAPITAL LATTERS)*

First Name :

Middle Name (s) :

Surname :

Date Of Birth : _____ / _____ / _____ **Sex at birth:** ☐ Male ☐ Female ☐ Intersex

Country Of Birth : _____ **Year Of Arrival In Australia:** _____

Current Address : _____

Phone Number : _____ **E-Mail** : _____

Medicare Number If Applicable : _____ **Individual Reference Number** : _____

Concession Card Number If Applicable : _____

Ehtnicity : _____

Does the patient identify as Aboriginal or Torres Strait Islander ?

☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal & Torres Strait Islander ☐ No, neither Aboriginal &nor Torres Strait Islander

HEALTH INFORMATION

Does your child have any allergies? ☐ No ☐ Yes- if yes please list: _____

Does your child have any current medical conditions? ☐ No ☐ Yes- if yes please list: _____

Was your baby born prematurely? ☐ No ☐ Yes- if how many weeks pregnant were you when you gave birth: _____

What was your child's weight at birth? _____

EMERGENCY CONTACT DETAILS

Contact Name : _____ **Mobile Number** : _____

Relationship : _____ **Email** : _____

I understand that this Immunisation Catch-Up Program is designed to provide a vaccination plan to bring my child's vaccinations in line with the recommended schedule set by the National Immunisation Program and any State based requirements. This process will result in a record being created for your child on The Australian Immunisation Record which will be accessible to all health practitioners.

I will provide the nurse with all requested information. I understand that in Australia, without written proof of vaccination and/or serological evidence of immunity (blood test), an individual is considered to be unimmunised.

I acknowledge that there are fees associated with this service, and I agree to pay them on the day payment is requested.
I have provided South Wangaratta Medical Centre with my child's original vaccination records from all countries where immunisation has been performed. If the records are not in English, I have supplied a translated copy obtained through the TIS (Translating and Interpreting Service) as instructed.

_____ **Parent/Guardian Name**

_____ **Parent/Guardian Signature**