

MURDOCH UNIVERSITY

Panvax [H1N1] Pre Vaccination Checklist

Patient Name _____

Date of Birth _____

Name of vaccine to be given **PANVAX**

Please circle Yes or No for each question.

Are you well today [no fever]? Yes / No

Do you have any allergies to anything [including eggs]? Yes / No

Have you had any severe reactions after vaccination? Yes / No

Have you ever fainted during or after vaccination? Yes / No

Are you pregnant or trying to get pregnant at present? Yes / No

Do you have a disease that lowers immunity or do you take medications which lower immunity [steroids/chemotherapy]? Yes / No

Are you on any medication to thin your blood? Yes / No

I have read the Panvax Patient Information at
<<http://www.healthemergency.gov.au/internet/healthemergency/publishing.nsf/Content/national-vaccination-program#handout>>
and am happy to proceed with the vaccination. Yes / No

Signature _____ Date _____

Medical staff only

Vaccination given by _____

Batch Number _____

Date _____