

## **INSTRUCTIONS FOR COMPLETING THE IMMUNISATION QUESTIONNAIRE AND CONSENT FORM**

1. Print out the Immunisation Questionnaire & Consent Form.
2. Complete **all** the details required including cost centre and fund number.
3. Ask the department contact (i.e. Resources Manager/Supervisor) to complete their details and sign where indicated (Part 1).
4. Ensure the form has been signed and dated by you (Part 3).
5. Place the completed form in a sealed envelope and mark it “confidential.”
6. Send (via internal mail) to:

Occupational Health Nurse Consultant  
Occupational Health and Safety  
26 Research Way  
Clayton Campus

When the form is received at Occupational Health and Safety you will then be notified (by mail) with details to arrange the necessary immunisation.

Please call one of the Occupational Health Nurse Consultants at Occupational Health and Safety on 9905 1014 if you have any queries.



## **MENINGOCOCCAL MENINGITIS IMMUNISATION QUESTIONNAIRE & CONSENT FORM**

### **A. Meningococcal C conjugate vaccines**

Sections 1-3 must be completed by the person requiring the immunisation prior to authorisation by OHS.

#### **Part 1 - Pre-Immunisation Details**

Surname ..... Given names .....

Date of Birth ..... M  F  I.D. Number ..... Tel .....

Department .....

..... Campus.....

Building ..... Room number..... Cost Centre ..... Fund No.....

Dept contact name..... Dept contact signature ..... Dept contact telephone..... Tel .....

#### **Part 2 – Reason for Immunisation and Medical History**

Reason for immunisation: (please tick) ✓  Clinical OR  Other .....

Please answer "yes" or "no" to the following questions:

- |  |  | YES                      | NO                       |
|--|--|--------------------------|--------------------------|
| 1. Have you ever had                               | - meningitis   | <input type="checkbox"/> | <input type="checkbox"/> |
|  | - serious chest infections                                 | <input type="checkbox"/> | <input type="checkbox"/> |
|  | - exposure to anyone known or suspected to have meningitis | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you allergic to phenol?                     |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you travelled recently in a malarial area? |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you currently have                           | - immune system deficiency                                 | <input type="checkbox"/> | <input type="checkbox"/> |
|  | - any allergies  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | - any illness  | <input type="checkbox"/> | <input type="checkbox"/> |

If yes to any of the above, please list

.....  
.....

5. Are you taking any medication (eg. tablets, capsules, puffers, creams)?  
If yes, please list

.....  
.....

6. Are you pregnant, trying to become pregnant or breast feeding?  YES  NO

7. Do you have any concerns about your health?  YES  NO

If yes, please list

.....  
.....

**Part 3 - Declaration**

1. I understand that a single injection of the meningococcal meningitis immunisation will be given subcutaneously.
2. I understand that repeat immunisation is generally not required.
3. I understand that reactions to the injection are similar to those after any immunisation, most commonly soreness and inflammation at the injection site. Less commonly fever and chills may occur. Upper respiratory tract illness, headache and lethargy occur occasionally. Allergic reactions are rare.
4. I understand that the immunisation should give antibody response to serogroup C forms of meningococcal infection, but it does not give protection from all forms of meningococcal infection.
5. I understand that part 4 of this form will be completed by the clinic which performs the immunisation. Once the course of immunisations has been completed, this form will be forwarded by the immunising clinic to OHS.
6. I understand that my Manager/Supervisor may be notified regarding my immunisation status.
7. I give my consent to be immunised with meningococcal C conjugate immunisation.

Signed: ..... Date: ...../...../.....

**Part 4 - Immunisation Record (To be completed by Doctor/Nurse)**

Date immunisation given: ..... Given By .....

Immunisation Trade-name: .....

Batch No: ..... Expiry Date: .....

**Part 5 - Privacy Statement**

The information on this form is collected for the primary purpose of providing high quality health care. It may also be used for a related secondary purpose that complies with legislative reporting requirements. The information collected on this form may be disclosed to others involved in your health care and government departments such as the Department of Human Services as required under mandatory reporting requirements. If all of the information requested is not provided, it may compromise the quality of the health care and treatment given to you, and may not be possible for the university to meet its legal obligations. You have a right to access personal information that Monash University holds about you, subject to any exceptions in relevant legislation. To do this, please contact the Monash University Privacy Officer at [privacyofficer@monash.edu](mailto:privacyofficer@monash.edu)