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
   30 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 Polysaccharide Questionnaire & Consent Form

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 ..............................................................

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:

1. Have you ever had
   – meningitis ☐ ☐
   – serious chest infections ☐ ☐
   – exposure to anyone known or suspected to have meningitis ☐ ☐

2. Are you allergic to phenol? ☐ ☐

3. Have you travelled recently in a malarial area? ☐ ☐

4. Do you currently have
   – immune system deficiency ☐ ☐
   – any allergies ☐ ☐
   – any illness ☐ ☐

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? ☐ ☐

7. Do you have any concerns about your health?
   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 the immunisation should last 3-5 years.
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 common 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 some (Groups A&C, possibly W135 &Y) 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 immunized with meningococcal polysaccharide immunisation.

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

Part 4 - Immunisation Record (To be completed by Doctor/Nurse)
Date immunisation given: .............................................................. Given by ..............................................................
Immunisation Trade-name: ..............................................................
Batch No: ........................................................................ Expire 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