

INSTRUCTIONS FOR COMPLETING THE IMMUNISATION QUESTIONNAIRE & CONSENT FORM

1. Complete **all** the details required including the cost centre and fund number.
2. Ask the department contact (i.e. Resources Manager/Supervisor) to complete their details and sign where indicated (Part 1).
3. Ensure the form has been signed and dated by you (Part 3).
4. Send via email from your staff/student email address to the Occupational Health Nurse Consultants at: BPD-OHNC@monash.edu

When the form is received at Occupational Health and Safety you will be notified (by email) with details of how 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.



TETANUS & DIPHTHERIA IMMUNISATION QUESTIONNAIRE & CONSENT FORM

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 number..... Room number Cost Centre _____ Fund No
 Dept contact name _____ Signature _____ Tel _____

Part 2 – Reason for Immunisation and Medical History

Reason for immunisation: (please tick) ✓ Working with animals OR Gardeners OR
 Facilities & Services workers OR Water studies worker OR
 Other

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

	YES	NO
1. Have you previously been immunised against tetanus and/or diphtheria? If yes, please give approximate date/s	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had - hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
- jaundice	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you currently have - yeast hypersensitivity	<input type="checkbox"/>	<input type="checkbox"/>
- immune system deficiency	<input type="checkbox"/>	<input type="checkbox"/>
- any allergies	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list		
- any illness	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list		
4. Are you taking any medication (e.g. tablets, capsules, puffers, creams)? If yes, please list	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant, trying to become pregnant or breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any concerns about your health?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list		

Part 3 - Declaration

- I understand that I will have a single injection in one of my arms and will require another booster in 10 years time. The ADT vaccine contains diphtheria toxoid, tetanus toxoid, aluminium phosphate and thiomersal.
- I understand that immunisation with ADT (combined tetanus and diphtheria) vaccine will, in most cases, result in the development of immunity to infection from tetanus and diphtheria both of which are very serious diseases.
- I understand that if I know I have had a severe reaction to tetanus toxoid in the past I should **not** have another injection of tetanus toxoid nor of ADT. I understand that if I am allergic to any of the constituents of ADT, I should **not** have an injection of ADT.
- I understand that I am advised not to have the vaccine if I am pregnant.
- I understand that the risk of any adverse reaction is very low, but there is a possibility of a reaction to the injection and that these reactions may include soreness, tenderness, redness, irritation and a small lump where the injection is given, lasting not more than a few days. In very rare cases, the reaction may be more severe and may require treatment. General reactions are extremely rare.
- I have read and understood the information about the possible reactions to injections with ADT.
- 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.
- I understand that my Manager/Supervisor may be notified regarding my immunisation status.
- I give my consent to be immunised against ADT.

Signed

Date

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

Trade Name

Batch

Expiry Date

Date Given

Given By

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