



Information about the Immunisation history form

Only use the Immunisation history form when the Australian Childhood Immunisation Register (the ACIR) does not have the complete immunisation history for a child and **another immunisation provider performed the service**. Report vaccinations you administered using the standard processes (i.e. Internet, Electronic Data Interchange, Immunisation encounter form or Medicare Australia's online claiming).

Proof of immunisation

- Obtain proof of immunisation before completing Part B of this form and signing the declaration at Part C (i.e. written documentation or confirmation from the previous immunisation provider).
- If the child's immunisation history is not available, and you believe that the child is age-appropriately immunised, tick the box at the bottom of Part B and include the date of the child's next due vaccination.

Immunisation details

- **Only include immunisations on this form that are not already recorded on the ACIR.** With parental/guardian consent, you can check a child's history on the ACIR by phoning the enquiry line on **1800 653 809****.
- The ACIR only records immunisations given on or after 1 January 1996 to children up to seven years of age.

Immunisation history details at Part B

- If you do not know the vaccine brand name, you can write the generic term in the '**Other (please specify)**' section (e.g. DTPa instead of Infanrix).
- If the child has received a vaccination for an antigen not shown on the form, write the vaccine brand name or antigen in the '**Other (please specify)**' section.

Immunisations given overseas

- If the immunisations were given to the child while overseas, note this in the '**if given overseas**' column.
- Please write the generic vaccine term in the '**Other (please specify)**' section if you do not know the vaccine brand name, or if it has not been in use in Australia (e.g. DTP will suffice for a diphtheria, tetanus and pertussis vaccine, as the vaccine term is well known).

Provider declaration

- A recognised immunisation provider must complete Part C (e.g. GP, council, health service, etc.).
- Supply your Medicare provider number (for medical practitioners) or ACIR registration number (for other immunisation providers) in the space provided.

Distribution

The Immunisation history form is produced in triplicate.

- Send the **ORIGINAL** to Medicare Australia, GPO Box 295, HOBART TAS 7001 or lodge at your nearest Medicare office.
- Retain the **PROVIDER'S COPY** for your own medical records.
- Ensure you give the **PARENT'S COPY** to the parent or guardian for their records.

Replacement stationery

You can request additional copies of the Immunisation history form by contacting the ACIR's stationery suppliers on **1800 067 307**** (quote form number IMMU-13). You can also print the form from the Medicare Australia website at www.medicareaustralia.gov.au then go to **Health Care Providers > Forms > Australian Childhood Immunisation Register Forms** – printed forms will not appear in triplicate.

Privacy note

The information provided by you on this form will be used to update the Australian Childhood Immunisation Register. The collection of information on this form is authorised by the *Health Insurance Act 1973*. The Immunisation Register may disclose this information to the Family Assistance Office, a parent or guardian of the stated child, and to authorised immunisation providers and bodies as authorised or required by law.

For further information about the ACIR, phone the enquiry line on 1800 653 809.**

** Call charges apply from mobile or pay phones only

Immunisation history form

CLAIM ID

Only immunisations that are not already recorded on the ACIR need to be included on this form.

Part A – Child's details

Medicare number Ref. no. Date of birth / / Male Female

Family name First given name Initial

Address Postcode

Part B – Immunisation details

Recommended age	Vaccines given (Please mark with an X)					Date of immunisation	X if given overseas
Birth	Engerix-B <input type="checkbox"/>	HBVax II <input type="checkbox"/>				/ /	<input type="checkbox"/>
2 months	Infanrix <input type="checkbox"/>	InfanrixHepB <input type="checkbox"/>	Infanrix Hexa <input type="checkbox"/>	Infanrix IPV <input type="checkbox"/>	Infanrix Penta <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Pediacel <input type="checkbox"/>	Poliacel <input type="checkbox"/>	Quadracel <input type="checkbox"/>	Tripacel <input type="checkbox"/>		/ /	<input type="checkbox"/>
	IPOL <input type="checkbox"/>	Oral Polio <input type="checkbox"/>				/ /	<input type="checkbox"/>
	Comvax <input type="checkbox"/>	PedvaxHIB <input type="checkbox"/>				/ /	<input type="checkbox"/>
	Prevenar <input type="checkbox"/>					/ /	<input type="checkbox"/>
	Rotarix <input type="checkbox"/>	RotaTeq <input type="checkbox"/>				/ /	<input type="checkbox"/>
	Other (please specify)					/ /	<input type="checkbox"/>
4 months	Infanrix <input type="checkbox"/>	InfanrixHepB <input type="checkbox"/>	Infanrix Hexa <input type="checkbox"/>	Infanrix IPV <input type="checkbox"/>	Infanrix Penta <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Pediacel <input type="checkbox"/>	Poliacel <input type="checkbox"/>	Quadracel <input type="checkbox"/>	Tripacel <input type="checkbox"/>		/ /	<input type="checkbox"/>
	IPOL <input type="checkbox"/>	Oral Polio <input type="checkbox"/>				/ /	<input type="checkbox"/>
	Comvax <input type="checkbox"/>	PedvaxHIB <input type="checkbox"/>				/ /	<input type="checkbox"/>
	Prevenar <input type="checkbox"/>					/ /	<input type="checkbox"/>
	Rotarix <input type="checkbox"/>	RotaTeq <input type="checkbox"/>				/ /	<input type="checkbox"/>
	Other (please specify)					/ /	<input type="checkbox"/>
6 months	Infanrix <input type="checkbox"/>	InfanrixHepB <input type="checkbox"/>	Infanrix Hexa <input type="checkbox"/>	Infanrix IPV <input type="checkbox"/>	Infanrix Penta <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Pediacel <input type="checkbox"/>	Poliacel <input type="checkbox"/>	Quadracel <input type="checkbox"/>	Tripacel <input type="checkbox"/>		/ /	<input type="checkbox"/>
	IPOL <input type="checkbox"/>	Oral Polio <input type="checkbox"/>				/ /	<input type="checkbox"/>
	Prevenar <input type="checkbox"/>					/ /	<input type="checkbox"/>
	RotaTeq <input type="checkbox"/>					/ /	<input type="checkbox"/>
	Other (please specify)					/ /	<input type="checkbox"/>
12 months	M-M-R II <input type="checkbox"/>	Priorix <input type="checkbox"/>				/ /	<input type="checkbox"/>
	Comvax <input type="checkbox"/>	Hiberix <input type="checkbox"/>	PedvaxHIB <input type="checkbox"/>			/ /	<input type="checkbox"/>
	Meningitec <input type="checkbox"/>	NeisVac-C <input type="checkbox"/>	Menjugate <input type="checkbox"/>			/ /	<input type="checkbox"/>
	Other (please specify)					/ /	<input type="checkbox"/>
18 months	Varilrix <input type="checkbox"/>	Varivax <input type="checkbox"/>				/ /	<input type="checkbox"/>
	Other (please specify)					/ /	<input type="checkbox"/>
4 years	Infanrix <input type="checkbox"/>	Infanrix IPV <input type="checkbox"/>	Quadracel <input type="checkbox"/>	Tripacel <input type="checkbox"/>		/ /	<input type="checkbox"/>
	IPOL <input type="checkbox"/>	Oral Polio <input type="checkbox"/>				/ /	<input type="checkbox"/>
	M-M-R II <input type="checkbox"/>	Priorix <input type="checkbox"/>				/ /	<input type="checkbox"/>
	Other (please specify)					/ /	<input type="checkbox"/>

OR Immunisation history is not available but I believe the child identified on this form is age appropriately immunised or is following an approved catch-up schedule. Date next vaccination due / /

Part C – Immunisation provider's details and declaration

Note: A recognised immunisation provider must complete and sign this section (e.g. GP, council, etc.).

Medicare provider/ACIR registration number Phone number ()

Provider name

I certify that the information provided on this form is true and correct, and that I have obtained proof of the vaccination(s) given.

Provider's signature Date / /

ORIGINAL Please return this form to Medicare Australia, GPO Box 295, HOBART TAS 7001 or your nearest Medicare office. For further information about the ACIR, phone 1800 653 809**.

** Call charges apply from mobile or pay phones only