Appendix 6: Staff and Volunteer Immunisation Form

IMMUNISATION FORM TO BE COMPLETED AND RETURNED TO THE IMMUNISATION SERVICE immunisationservice@cabrini.com.au	
PLEASE PRINT CLEARLY	
Surname:	
Given Name/s:	**Preferred Name:**
Date of Birth:	**Gender:** Male Female
Employee No. (if known):	**Country of Birth:**
Phone Number:	**Department/Ward:**
Position Title:	**Campus:**
Email Address:	

COVID-19 VACCINATION – attach evidence of vaccination	
Dose 1: Date	**Brand:**
Dose 2: Date	**Brand:**
Dose 3: Date	**Brand:**
Dose 4: (optional)	**Brand:**

INFLUENZA VACCINE – attach evidence of vaccination (Cabrini offers an annual vaccine free of charge)	
Date:	(**attach evidence)**

PERTUSSIS VACCINE dTpa (Whooping Cough - Boostrix or Adacel) – attach evidence of vaccination	
Date:	Required within the last 10 years (**attach evidence)**

SEROLOGY – attach copies of serology/blood test results	
Measles	**(attach evidence)**
Mumps	**(attach evidence)**
Rubella	(**attach evidence)**
Varicella (Chickenpox)	(**attach evidence)**
Hepatitis B **(HBsAb)**	(**attach evidence)**
QuantiFERON Gold (TB) see page 3 and 4	(**attach evidence)**

Hepatitis B – Non-Responder If yes – GP letter to be provided to the Cabrini Immunisation Service

Hepatitis B – **Non-clinical** (Clerical/Administration only) - Eligible to decline Hepatitis B Immunisation (Call the Cabrini Immunisation Service on 95081018 to discuss options other than vaccination)
Hepatitis A – Plumbers and/or Engineers (only) who work with sewage systems (**attach evidence)**

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TURBERCULOSIS	Yes	No
Were you born in a country with a high incidence of TB? (see page 4)		
Have you worked for a cumulative period of 3 months or more in a country with a high incidence of TB? (see page 4)		
Have you worked with an indigenous community in Northern Australia for a cumulative period of 3 months or more?		
Have you worked in a TB / chest clinic?		

NOTE: IF **YES** TO ANY OF THE ABOVE QUESTIONS – QuantiFERON Gold test required- **attach copy of serology/blood result**

QuantiFERON Gold TB Test	Date:
Note: If positive result, GP to provide 'fit to work' letter	

MENINGOCOCCAL – **MICRO-LAB STAFF ONLY - attach evidence of vaccination**	
Meningococcal ACWY Vaccine **to be given 5 yearly**	Date of last vaccine:
Meningococcal B (Bexsero) x2 doses	Dates: (/ / dose 1) (/ / dose 2)

I provide consent for Cabrini's Immunisation Service to access my immunisation history on the Australian Immunisation Register for the purpose of checking my vaccination status in accordance with the Immunisation Policy and Protocol Yes ☐ No ☐

CHECKLIST (Please return the below to the Immunisation service)

- ☐ Immunisation Form
- ☐ Evidence of COVID-19 vaccination
- ☐ Serology – Provide Evidence for **ALL**
  - Measles
  - Mumps
  - Rubella
  - Varicella
  - Hepatitis B (HBsAB)
  - Tuberculosis
- ☐ Evidence of Pertussis vaccination (Boostrix or Adacel)
- ☐ Evidence of Influenza vaccination
- ☐ Evidence of Meningococcal vaccines (ACYW and B) (Micro-Lab staff only)
- ☐ Evidence of Hepatitis A vaccine or Hepatitis A serology (Plumbers/Engineers staff only)
- ☐

DECLARATION

I declare that the information I have provided is accurate and I have not withheld any relevant information.

Signature: ______________________________ Date: / /

PLEASE RETURN FORM & DOCUMENTS TO THE IMMUNISATION SERVICE

immunisationservice@cabrini.com.au