

Tasmanian STUDENT IMMUNISATION RECORD






PERSONAL DETAILS (Please print)			
Surname: Jones		Given Names: Emily Kate	
Address: 12 Smith Street, Hobart			
Post Code: 7000	State: TAS	Mobile: 0412 345 678	
Date of Birth: 11/100		Student ID: 123456	

Student Declaration:

I agree to have my immunisation requirements contained in this Immunisation Record documented and will produce my Immunisation Record for sighting by PEP agencies if/when required.

Signature:  Date: 01/10/18

Vaccine (Mandatory)	Date of administration and/or serology	Batch Number	Vaccination provided by or evidence sighted by - Clinic/practice stamp or name and signature required
<b>Adult formulation: diphtheria, tetanus, acellular pertussis (whooping cough) vaccine (ADULT dose of dTpa)</b>			
Dose 1			Dr Full Moon
Booster (every 10 years)	01/12/2017	AC37BC75	Milky Way General Practice Southern Cross Drive
<b>Hepatitis B Vaccine (age appropriate course of vaccinations AND hepatitis B surface antibody &gt; 100mIU/ml OR hepatitis B core antibody positive)</b> Outer Galaxy TAS 7309 Provider No.: 1234567A			
Dose 1	01/11/2017	AHBVC123C	Dr Full Moon
Dose 2	03/12/2017	AHBVC8586C	Milky Way General Practice
Dose 3	02/09/2018	AHBVC217C	Southern Cross Drive
AND			Outer Galaxy TAS 7309 Provider No.: 1234567A
Serology: anti-HBs (4-6 weeks after 3 <sup>rd</sup> dose)	15/07/2018	Result 878 ml/IUml	Dr Full Moon
OR Serology: anti-HBc		Positive (please circle)	Milky Way General Practice Southern Cross Drive
<b>Measles, Mumps, Rubella (MMR) vaccine</b> (2 doses MMR vaccine at least 1 month apart OR positive serology for measles and mumps and numerical titre level for rubella only OR born before 1966) Outer Galaxy TAS 7309 Provider No.: 1234567A			
Dose 1	03/01/2018	A69FC720A	Dr Full Moon
Dose 2	04/02/2018	A695C456A	Milky Way General Practice
OR			Southern Cross Drive
Serology Measles	05/02/2018	IgG result positive	Outer Galaxy TAS 7309
Serology Mumps	05/02/2018	IgG result positive	Provider No.: 1234567A
Serology Rubella	05/02/2018	ml/IUml result 50.51	
<b>Varicella vaccine</b> (age appropriate course of vaccination OR positive serology)			
Dose 1	03/01/2018	G000987	Dr Full Moon
Dose 2	04/02/2018	G000765	Milky Way General Practice
OR Serology Varicella	06/03/2018	IgG result positive	Southern Cross Drive
<b>Influenza vaccine (required annually two weeks prior to June 1) in Tasmania</b> Outer Galaxy TAS 7309 Provider No.: 1234567A			
The Safety in Practice Influenza Vaccination form can be accessed at: <a href="http://www.utas.edu.au/health/professional-experience-placement/safety-in-practice-requirements">http://www.utas.edu.au/health/professional-experience-placement/safety-in-practice-requirements</a>			

TB Questionnaire (Mandatory)	Date		Clinic/practice stamp or full name and signature required
Complete all questions	01/12/2017	Yes <input type="radio"/> No <input checked="" type="radio"/> (please circle)	Assessed by Health Care Provider   Dr Full Moon Milky Way General Practice Southern Cross Drive Outer Galaxy TAS 7309 Provider No.: 1234567A
Is BCG Scar present?	01/12/2017	Yes <input type="radio"/> No <input checked="" type="radio"/>	
Was the student born outside of Australia?	01/12/2017	Yes <input type="radio"/> No <input checked="" type="radio"/> If yes, where was the student born?	
Has the student lived in or travelled to a country with a high incidence of TB?		Yes <input type="radio"/> No <input checked="" type="radio"/>	
To view countries of high TB incidence please go to: <a href="http://www.health.nsw.gov.au/Infectious/tuberculosis/Documents/countries-incidence.pdf">http://www.health.nsw.gov.au/Infectious/tuberculosis/Documents/countries-incidence.pdf</a>			
Has the student been in physical contact with a person known to have TB?	01/12/2017	Yes <input type="radio"/> No <input checked="" type="radio"/>	← this is provided free of charge if required during Orientation
If the answer to any of the above is yes, this student does require TB screening.		Refer the student to the Respiratory Clinic at the RHH or LGH to complete a Mantoux test.	
<b>TB Screening (If Required)</b> Tuberculin Skin Test (Mantoux)	Date		
Skin Test			Given by - Clinic/practice stamp or name and signature required  Dr Full Moon Milky Way General Practice Southern Cross Drive Outer Galaxy TAS 7309 Provider No.: 1234567A
Reading		Induration mm	
Skin Test			
Reading		Induration mm	
<b>Testing for Blood-borne Viruses to determine infectivity status (Mandatory)</b> DO NOT RECORD RESULTS			Evidence sighted by Health Care Provider - Name & signature required
<b>Human Immunodeficiency syndrome (HIV)</b>			
HIV antibody test	Yes <input checked="" type="radio"/> (please circle)	Date of Serology: 05/02/2018	
<b>Hepatitis B virus (HBV)</b>			
HBsAg Test If positive further testing to determine the degree of infectivity: HBeAg & HBV DNA	Yes <input checked="" type="radio"/> (please circle)	Date of Serology: 05/02/2018	 Dr Full Moon Milky Way General Practice Southern Cross Drive Outer Galaxy TAS 7309 Provider No.: 1234567A
<b>Hepatitis C virus (HCV)</b>			
HCV antibody test If HCV antibody positive, further testing for HCV RNA	Yes <input checked="" type="radio"/> (please circle)	Date of Serology: 05/02/2018	
<b>HEALTH CARE PROVIDER DECLARATION</b>			
<b>Where applicable (tick box):</b> <ul style="list-style-type: none"> <li>If the student has had a positive result for a blood borne virus or TB, I have arranged further testing, advice and treatment. <input type="checkbox"/></li> <li>If the student has a blood-borne virus or has/had tuberculosis or has a medical contraindication to a vaccination or is a documented non-responder to a vaccination, a <i>Safety in Practice Immunisation Variation form</i> must be completed. The <i>Safety in Practice Immunisation Variation form</i> can be accessed at: <a href="http://www.utas.edu.au/health/professional-experience-placement/safety-in-practice-requirements">http://www.utas.edu.au/health/professional-experience-placement/safety-in-practice-requirements</a>. I have completed and returned the <i>Safety in Practice Immunisation Variation Form</i> to the student to submit to their Program PEP Coordinator/Administrator. <input type="checkbox"/></li> </ul>			
<b>Practitioner to Complete</b> Name: Dr Full Moon ..... Provider Number: 1234567A ..... Signature:  ..... Date: 01/01/2018 .....			