

Information you need to know about the immunisation history form

When to use this 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 administered using the standard processes (i.e. Internet, Electronic Data Interchange, Immunisation encounter form or Medicare'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 last 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**. **Note:** call charges apply from mobile phones.
- The ACIR only records immunisations given on or after 1 January 1996 to children up to seven years.

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.

Returning your form

The Immunisation history form is produced in triplicate.

- Send the **ORIGINAL** to the Department of Human Services, GPO Box 295, HOBART TAS 7001 or lodge at your local Medicare Service Centre.
- Retain the **PROVIDER'S COPY** for your own medical records.
- Ensure the **PARENT'S COPY** is given to the parent or guardian for their records.

Replacement stationery

Additional copies of the Immunisation history form can be requested by contacting the ACIR's stationery suppliers on 1800 067 307 (quote form number IMMU-13), or printed by going to our website humanservices.gov.au/provider > **Forms publications and statistics** > **Other program forms** > **ACIR forms** – printed forms will not appear in triplicate.

Privacy notice

Centrelink, Medicare Australia, Child Support and CRS Australia are services within the Australian Government Department of Human Services (Human Services).

Your personal information is protected by law, including the *Privacy Act 1988*. Your information is collected for Social Security, Family Assistance, Medicare, Child Support and CRS purposes. This information may be required by the powers provided within each services' legislation or voluntarily given by you when you apply for services or payments.

Your information will be used for the assessment and administration of payments and services. Your information may also be used within Human Services, where you have provided consent or it is required or authorised by law. Human Services may disclose your information to Commonwealth departments, other persons, bodies or agencies **ONLY** where you have provided consent or it is required or authorised by law.

You can get more information about privacy by going to our website humanservices.gov.au/privacy or requesting a copy of the full privacy policy at one of our Service Centres.

For more information

For further information about the ACIR go to our website humanservices.gov.au/acir or call **1800 653 809**.

Australian Childhood Immunisation Register immunisation history form

CLAIM ID

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

Recommended age	Vaccines given (Please mark with an X)					Date of immunisation	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 Telephone 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 / /

Please return this form to the Department of Human Services, GPO Box 295, HOBART TAS 7001 or your local Medicare Service Centre. For further information about the ACIR go to our website humanservices.gov.au/acir or call **1800 653 809**.

Note: Call charges apply from mobile phones.



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