|  |  |  |
| --- | --- | --- |
| **ANY OF FOLLOWING QUEST IS YES, YOU WILL NOT HAVE VACCINE TODAY** | **Yes** | **No** |
| Check which of the below vaccines you have received in the last 30 days, or that you plan to receive in the next 60 days:  **MMR, Varicella (chicken pox), Zoster (shingles) vaccine** |  |  |
| Infants with a body mass below 2,000g. |  |  |
| Newborn children with suspected congenital immune deficiencies |  |  |
| Persons who have had a tuberculin skin test (TST) reaction. |  |  |
| Persons who have TB disease now, or have had TB disease in the past. |  |  |
| Persons with HIV infection; including newborn children of mothers infected with HIV until this infection is ruled out in the child. |  |  |
| Newborn children of mothers treated in their third trimester with medications such as anti-TNF-alpha monoclonal antibodies. |  |  |
| Persons with primary or secondary immune deficiencies (including interferon-gamma deficiency and DiGeorge syndrome) |  |  |
| Persons who take anti-cancer or steroid drugs such as cortisone or immunosuppressive drugs(including anti-TNF-alpha monoclonal antibodies such as infliximab) or are undergoing radiotherapy |  |  |
| **Persons who take steroid drugs such as cortisone** |  |  |
| Patients after bone marrow stem cell transplantation or organ transplantation |  |  |
| Persons who have had a serious illness such as kidney disease. |  |  |
| Patients with malignant diseases (e.g. leukaemia, Hodgkin lymphoma, lymphoma, or other carcinoma of the reticuloendothelial system); |  |  |
| Patients after bone marrow stem cell transplantation or organ transplantation; |  |  |
| People with generalised skin diseases such as eczema or other exudative inflammatory dermatological conditions |  |  |
| People with known hypersensitivity to any component of the vaccine. |  |  |
| Pregnant women, Persons with serious diseases (including severe malnutrition) |  |  |
| Extensive dermatitis or Eczema |  |  |
|  |  |  |

**Pakenham Medical Clinic. 48 Main Street, Pakenham 3810.**

**BCG VACCINATION CKECK LIST**

Name: -----------------------------------------------------------------------------------DOB-------------------

Address---------------------------------------------------

Medical Condition(s) not listed above: -------------------------------------------------

Medications (including antacids/Prilosec):------------------------------------------------------

Allergies & Reaction to meds, vaccines, food, insects: --------------------------------------

I understand that this request is for BCG fever vaccine only, I have given all possible information

Signature Date