AUSTRALIAN CHILDHOOD IMMUNISATION REGISTER (ACIR)
DECLARATION OF VACCINE EXEMPTION DUE TO MEDICAL CONTRAINDICATION

PRIVACY NOTE: The information on this form will be recorded on the Australian Childhood Immunisation Register (ACIR). The establishment of the ACIR is authorised by the Health Insurance Act 1973.

THIS FORM MUST BE COMPLETED BY A RECOGNISED IMMUNISATION PROVIDER

COMPLETE THIS SECTION WITH DETAILS OF THE CHILD YOU WISH TO DECLARE A VACCINE EXEMPTION DUE TO MEDICAL CONTRAINDICATION

Medicare Number ☐☐☐☐☐☐☐☐☐☐

Reference Number ☐
(Number next to child on Medicare Card)

First Name _____ Second Initial _____

Surname _____

Residential Address _____

Suburb/Town _____ Postcode ☐☐☐☐

Date of Birth ☐☐☐☐☐☐

Gender Male ☐ Female ☐

Please indicate the vaccine(s) exempt due to Medical Contraindication.

Diphtheria, Tetanus, Pertussis (DTP) singular, or containing Hepatitis B

☐ Infanrix ☐ Tripacel ☐ InfanrixHepB

Haemophilus influenzae type b (Hib) singular, or containing Hepatitis B

☐ PedvaxHIB ☐ COMVAX ☐ Hiberix ☐ HibTITER

Measles, Mumps, Rubella (MMR)

☐ MMRII ☐ Priorix

Other vaccine (not listed above) Vaccine name: _____

Note: *IPV can be given instead of OPV where immunosuppression exists in patients or close contacts.*

The latest edition of the Australian Immunisation Handbook contains full details of contraindications to vaccination. Any adverse reaction to an immunisation should be reported to the relevant State or Territory Health Authority. A list of telephone numbers is available in the Australian Immunisation handbook.

I DECLARE THAT I BELIEVE THAT THE CHILD IDENTIFIED ON THIS FORM SHOULD HAVE A VACCINE EXEMPTION DUE TO A MEDICAL CONTRAINDICATION FOR ONE OF THE FOLLOWING REASONS:

☐ Unstable neurological disease
☐ Encephalopathy within 7 days after a previous vaccination
☐ Immediate severe acute allergic or anaphylactic reaction after previous DTP vaccination
☐ Malignant disease and/or immunosuppressive therapy
☐ Allergy to neomycin
☐ Severe local or general reaction which can confidently be related to previous Hib vaccination
☐ The child has a non-permanent contraindication and vaccination is deferred to this date: ☐☐☐☐☐☐

Medicare/Immunisation Provider Number ☐☐☐☐☐☐☐☐

Signature _____ Date ☐☐☐☐☐☐

Please provide an estimate of time taken to complete this form including reading instructions & collecting information. ☐ Mins

Please return this completed form to the Health Insurance Commission GPO Box 295 HOBART TAS 7001, your nearest Medicare Office or via facsimile to (03) 6215 5686.
For further information ring 1800 653 809 (freecall).