

Babies details

Baby's surname or family name _____ Baby's first or given name _____

Baby's NHI number _____ Baby's date of birth _____ Baby's place of birth (birthing facility) _____

Gender Male Female Unknown Indeterminate

Ethnicity: Māori NZ European Samoan Cook Island Maori Tongan Chinese Nuiean Indian
Other European Other

Baby's physical address

Baby's postal address (if different to physical address)

Contact phone number _____ Second contact number (if applicable) _____

Parent/guardian details

<p>Mothers NHI number</p> <p>Contact name (must be parent/guardian if under 16 years)</p> <p>Relationship to baby Mother Father Other</p> <p>Physical address (if different to baby's address)</p> <p>Email address</p> <p>Main contact number Alternative contact number</p>	<p>Alternative contact name</p> <p>Relationship to baby Mother Father Other</p> <p>Physical address (if different to baby's address)</p> <p>Email address</p> <p>Main contact number Alternative contact number</p>
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Neonatal immunisation (Please record any immunisation given)

Event Codes: Completed Codes: F – Completed Declined Codes: DMC – Permanent contraindication DNI – Declined natural immunity
Rescheduled Codes: RESTC – Temporary contraindication RESREF – Referred elsewhere for immunisation RESCHO – Parent or individual choice to reschedule
Body Sites: RVL – Right Vastus Lateralis (Outer thigh) LVL – Left Vastus Lateralis (Outer thigh) RD – Right Deltoid (Upper arm) LD – Left Deltoid (Upper arm) O – Other

Vaccine given	Event code (see above)	Date DD/MM/YYYY	Batch number(s)	Expiry date DD/MM/YYYY	Body site (see above)	Vaccinator Name and ID (MCNZ,NZNC)
Hep B Paed						
HBIG						
BCG						

Adverse events following immunisation (AEFI). Please report AEFIs to CARM

Opting off the National Immunisation Register Note: If relevant, both boxes must be ticked

The parent/guardian is opting off having their baby's immunisation data on the NIR.

Opt off authorisation form (NIR2) has been given to the parent or guardian to send to the DHB NIR administrator

Provider details

Lead maternity carer (LMC) _____ LMC phone number _____

Well Child/Tamariki Ora provider (WCP) _____ WCP phone number _____

General practitioner (GP) Primary care provider/Authorised provider _____ GP/Primary care provider/Authorised provider phone number _____

Practice or clinic _____ The above information is correct. Signature of vaccinator _____ Date _____

Name of provider signing form _____