

# Vaccination recording form

## A. Individual details

Family name \_\_\_\_\_ Given names \_\_\_\_\_

NHI number \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Phone number \_\_\_\_\_  
Including area code if it is a landline

Which ethnic group do you belong to? Tick one or more that apply.

NZ European  Māori  Samoan  Cook Island Māori  Tongan  Niuean  Chinese  Indian

Other (such as Dutch, Japanese, Tokelauan). Please state \_\_\_\_\_

Street address \_\_\_\_\_ Suburb \_\_\_\_\_

Town, city or district \_\_\_\_\_ Postcode \_\_\_\_\_

General practice (GP)/Primary care provider \_\_\_\_\_

## B. Contact person details (for individuals under 16 years)

Contact name \_\_\_\_\_ Phone number \_\_\_\_\_

Relationship to individual  Parent  Other \_\_\_\_\_ Email \_\_\_\_\_

Street address \_\_\_\_\_ Suburb \_\_\_\_\_

Town, city or district \_\_\_\_\_ Postcode \_\_\_\_\_

Alternative contact name \_\_\_\_\_ Phone number \_\_\_\_\_  
Including area code if it is a landline

Relationship to individual  Parent  Other \_\_\_\_\_ Email \_\_\_\_\_

## C. Vaccination details Informed consent obtained

Vaccine	Vaccine product/ brand	Dose #	Indication	Vaccine batch number	Vaccine expiry	Diluent batch number (As required)	Diluent expiry (As required)	Route	Body site	Event code
RV1										
DTaP-IPV-HepB/Hib										
PCV13										
MenB										
MMR										
Hib										
VV										
DTaP-IPV										
Tdap										
HPV9										
Influenza										
COVID-19										
rZV										
MenACWY										

*Indication, route, body site and event codes can be found on back page.*

## D. Vaccinator and facility details

Vaccinator name \_\_\_\_\_ HPI-CPN or APC \_\_\_\_\_

Facility name \_\_\_\_\_ Facility phone number \_\_\_\_\_  
Including area code if it is a landline

Vaccinator signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

VHW supervisor name \_\_\_\_\_ VHW supervisor signature \_\_\_\_\_

Please enter immunisation details into the Aotearoa Immunisation Register (AIR) as soon as able. Once entered, please use secure destruction process.

## Indication codes

<b>1</b> Influenza, eligible over 65 years	<b>12</b> At risk, no previous history	<b>6W</b> 6 weeks
<b>2</b> Influenza, eligible under 18 years	<b>13</b> At risk, previous PCV history	<b>3M</b> 3 months
<b>3</b> Influenza, eligible criteria	<b>14</b> At risk, previous 23PPV	<b>5M</b> 5 months
<b>4</b> Sexual or household contact	<b>16</b> Pregnant	<b>12M</b> 12 months
<b>5</b> Primary course	<b>21</b> PCV catch up	<b>15M</b> 15 months
<b>6</b> Booster	<b>STN</b> Funded, if not otherwise specified	<b>4Y</b> 4 years
<b>7</b> Post partum	<b>96</b> HepB high risk, booster or extra dose	<b>11Y</b> 11 years
<b>8</b> Low birth weight	<b>TPW</b> Tetanus-prone wound	<b>14Y</b> 14 years
<b>9</b> HepB carrier mother	<b>5P</b> Privately funded, primary course	<b>45Y</b> 45 years
<b>10</b> At risk for TB	<b>6P</b> Privately funded, booster	<b>65Y</b> 65 years
<b>11</b> Post splenectomy schedule		

Route codes	Body site codes	Event codes	
<b>ID</b> Intradermal	<b>RT</b> Right thigh	<b>F</b> Completed	<b>DMC</b> Permanent contraindication
<b>IM</b> Intramuscular	<b>LT</b> Left thigh	<b>DIC</b> Declined by individual	<b>DNI</b> Immune
<b>OR</b> Oral	<b>RA</b> Right upper arm	<b>DPC</b> Declined by parent	
<b>SC</b> Subcutaneous	<b>LA</b> Left upper arm		

**VHW** Vaccinating Health Worker