

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

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

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

VHW Vaccinating Health Worker