|  |  |
| --- | --- |
|  | Immunisation Declaration |

# Staff Member/Student To Complete

|  |  |  |  |
| --- | --- | --- | --- |
| **Family Name** |  | **University ID** | U |
| **Given Names** |  | **Telephone** |  |
| **Address** |  | | |
| **Date of Birth** |  | **Medicare No.** |  |
| **College/Div/Centre** |  | **Dept/School/Section** |  |

# Medical Provider To Complete

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **I declare that I have administered vaccine to the staff member/student identified on this form as follows:**   |  |  |  |  | | --- | --- | --- | --- | | **Vaccine** | **Date of Serology Test** (if applicable) | **Results of Serology Test** (if applicable) | **Date of Vaccination** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |  |  |  |  | | --- | --- | --- | | **Name:** | **Signature:** | **Date:** | | **Qualification:** | **Medicare Provider No/ACIR Registration No.** | | |

**The staff member/student should discuss his/her immunisation status with his/her supervisor. The completed form should be forwarded to Injury Prevention at** [**injurymanagement@anu.edu.au**](mailto:injurymanagement@anu.edu.au) **for inclusion on the staff member’s/student’s personal file.**