

# Example Vaccination Record Card

## Vaccination Record Card for Category A Workers (including Students)



Personal Details (please print)

Please refer to instructions on page 3

|                  |                                       |                      |                      |
|------------------|---------------------------------------|----------------------|----------------------|
| Surname          | Doe                                   | Given Names          | Jane Anne            |
| Address          | 123 Main Street Bankstown             |                      |                      |
| State            | NSW                                   | P/code               | 2200                 |
| Date of Birth    | 20/02/2002                            |                      |                      |
| Staff/student ID | 20000000 -                            |                      |                      |
| Email            | 20000000@student.westernsydney.edu.au |                      |                      |
| Contact Numbers  | Mobile: 0404 040 404                  | Work:                |                      |
| Medicare Number  | 0244 44 227 7                         | Position on card: 01 | Expiry date: 04/2031 |

This section  
to be filled  
out by the  
student.

This should be  
your Western  
Student number.

This should be  
your Western  
Student email.

Everything below  
this line should  
be filled out by  
a (GP) General  
Practitioner

| Vaccine                                                                                                                                                                        | Date    | Batch No. (where possible)<br>or Brand name                                                                                        | Official Certification by Vaccination Provider (clinic/<br>practice stamp, full name and signature next to each entry)                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Adult formulation diphtheria, tetanus, acellular pertussis (whooping cough) vaccine (adult dose of dTpa vaccine)</b>                                                        |         |                                                                                                                                    |                                                                                                                                               |
| Dose 1                                                                                                                                                                         | 1/6/22  | AC 37 34 00 AE                                                                                                                     | CA [Signature] Health<br>NSW Government Western Sydney<br>Local Health District<br>Employment Health Assessment<br>C. Hockley RN NMW001212099 |
| Booster<br>10 years after previous dose                                                                                                                                        |         |                                                                                                                                    |                                                                                                                                               |
| Booster<br>10 years after previous dose                                                                                                                                        |         |                                                                                                                                    |                                                                                                                                               |
| <b>COVID-19 vaccine (TGA approved/recognised vaccine)</b>                                                                                                                      |         |                                                                                                                                    |                                                                                                                                               |
| Primary course (2 doses)                                                                                                                                                       |         | AIR statement or COVID-19 digital<br>certificate attached<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   | NOT REQUIRED                                                                                                                                  |
| Dose 3 or Booster dose                                                                                                                                                         |         | AIR statement or COVID-19 digital<br>certificate attached<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   | NOT REQUIRED                                                                                                                                  |
| OR Evidence of a<br>temporary or permanent<br>medical contraindication                                                                                                         |         | AIR immunisation medical<br>exemption form (IM011) attached<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | NOT REQUIRED                                                                                                                                  |
| <b>Hepatitis B vaccine (age appropriate course of vaccinations AND hepatitis B surface antibody <math>\geq 10</math> mIU/mL OR core antibody positive)</b>                     |         |                                                                                                                                    |                                                                                                                                               |
| Dose 1                                                                                                                                                                         | 1/6/22  | ENERGIX B AHD0007                                                                                                                  | CA [Signature] Health<br>NSW Government Western Sydney<br>Local Health District<br>Employment Health Assessment<br>C. Hockley RN NMW001212099 |
| Dose 2                                                                                                                                                                         | 1/7/22  | ENERGIX B AHD0007                                                                                                                  | CA [Signature] Health<br>NSW Government Western Sydney<br>Local Health District<br>Employment Health Assessment<br>C. Hockley RN NMW001212099 |
| Dose 3                                                                                                                                                                         | 1/11/22 | ENERGIX B AHD0007                                                                                                                  | CA [Signature] Health<br>NSW Government Western Sydney<br>Local Health District<br>Employment Health Assessment<br>C. Hockley RN NMW001212099 |
| <b>AND</b>                                                                                                                                                                     |         |                                                                                                                                    |                                                                                                                                               |
| Serology: anti-HBs<br>(Numerical value)                                                                                                                                        | 2/1/23  | Result 502 mIU/mL                                                                                                                  | CA [Signature] Health<br>NSW Government Western Sydney<br>Local Health District<br>Employment Health Assessment<br>C. Hockley RN NMW001212099 |
| OR Serology: anti-HBc                                                                                                                                                          |         | Result Positive Negative                                                                                                           |                                                                                                                                               |
| <b>Measles, Mumps and Rubella (MMR) vaccine<br/>(2 doses MMR vaccine at least 1 month apart OR positive serology for measles, mumps and rubella OR birth date before 1966)</b> |         |                                                                                                                                    |                                                                                                                                               |
| Dose 1                                                                                                                                                                         |         |                                                                                                                                    |                                                                                                                                               |
| Dose 2                                                                                                                                                                         |         |                                                                                                                                    |                                                                                                                                               |
| Booster if required                                                                                                                                                            |         |                                                                                                                                    |                                                                                                                                               |
| <b>OR</b>                                                                                                                                                                      |         |                                                                                                                                    |                                                                                                                                               |
| Serology Measles                                                                                                                                                               | +ve     | IgG Result CA                                                                                                                      | CA [Signature] Health<br>NSW Government Western Sydney<br>Local Health District<br>Employment Health Assessment<br>C. Hockley RN NMW001212099 |
| Serology Mumps                                                                                                                                                                 | +ve     | IgG Result CA                                                                                                                      |                                                                                                                                               |
| Serology Rubella (include numerical value and immunity status as per lab report: Positive / Negative / Indeterminate / Not tested / Not required)                              |         |                                                                                                                                    |                                                                                                                                               |
|                                                                                                                                                                                | 22      | IgG Result CA                                                                                                                      |                                                                                                                                               |

All vaccination  
entries require  
a GP signature  
and clinic  
stamp.

# Example Vaccination Record Card

This section  
to be filled  
out by the  
student.

## Personal Details (please print)

|               |                      |                  |           |
|---------------|----------------------|------------------|-----------|
| Surname       | Doe                  | Given name:      | Jane Anne |
| Date of Birth | 20/02/2002           | Staff/student ID | 20000000  |
| Contact       | Mobile: 0404 040 404 | Work:            |           |

| Vaccine                                                                                                                                                    | Date                                                     | Batch No. (where possible) or Brand name                                          | Official Certification by Vaccination Provider (clinic/practice stamp, full name and signature next to each entry) |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <b>Varicella vaccine</b> (age appropriate course of vaccination OR positive serology OR AIR history statement that records natural immunity to chickenpox) |                                                          |                                                                                   |                                                                                                                    |
| Dose 1                                                                                                                                                     | <input type="checkbox"/> Tick if given prior to 14 years |                                                                                   |                                                                                                                    |
| Dose 2                                                                                                                                                     |                                                          |                                                                                   |                                                                                                                    |
| Booster if required                                                                                                                                        |                                                          |                                                                                   |                                                                                                                    |
| OR                                                                                                                                                         |                                                          |                                                                                   |                                                                                                                    |
| Serology Varicella                                                                                                                                         | +ve                                                      | IgG Result                                                                        | AS                                                                                                                 |
| OR                                                                                                                                                         |                                                          |                                                                                   |                                                                                                                    |
| Australian Immunisation Register (AIR) History Statement that records natural immunity to chickenpox                                                       |                                                          | AIR Statement Sighted<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                    |

| Vaccine                                                                                                         | Date   | Batch No. (where possible) or Brand name                            | Official Certification by Vaccination Provider (clinic/practice stamp, full name and signature) |
|-----------------------------------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <b>Influenza vaccine</b> (strongly recommended for all workers & mandatory for Category A workers and students) |        |                                                                     |                                                                                                 |
|                                                                                                                 |        |                                                                     |                                                                                                 |
|                                                                                                                 |        |                                                                     |                                                                                                 |
|                                                                                                                 |        |                                                                     |                                                                                                 |
| <b>TB Screening</b>                                                                                             |        |                                                                     |                                                                                                 |
|                                                                                                                 | Date   | Batch No. or Result                                                 | Assessed by/Given by/Read by (clinic/practice stamp, full name and signature)                   |
| Requires TB screening?                                                                                          |        | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                 |
| Past vaccination BCG                                                                                            |        | <input type="checkbox"/> YES <input type="checkbox"/> NO            |                                                                                                 |
| <b>Interferon Gamma Release Assay (IGRA) (circle test result)</b>                                               |        |                                                                     |                                                                                                 |
| IGRA                                                                                                            | 1/6/22 | Positive Indeterminate <u>Negative</u>                              | AS                                                                                              |
| IGRA                                                                                                            |        | Positive Indeterminate Negative                                     |                                                                                                 |

| <b>Tuberculin Skin Test (TST) – TB Service/Chest Clinic only</b>                          |  |                                                          |  |
|-------------------------------------------------------------------------------------------|--|----------------------------------------------------------|--|
| TST Administration                                                                        |  |                                                          |  |
| TST Reading                                                                               |  | Induration mm                                            |  |
| TST Administration                                                                        |  |                                                          |  |
| TST Reading                                                                               |  | Induration mm                                            |  |
| Referral to TB Service/Chest Clinic for TB Clinical Review required?                      |  | <input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| <b>TB Clinical Review</b>                                                                 |  |                                                          |  |
| Chest X-ray                                                                               |  |                                                          |  |
| Other                                                                                     |  |                                                          |  |
|                                                                                           |  |                                                          |  |
| <b>TB Compliance – TB Service/Chest Clinic or OASV Assessor (circle correct response)</b> |  |                                                          |  |
| TB Compliance Assessment                                                                  |  | Compliant<br>Temporary Compliance<br>Non-compliant       |  |
| TB Compliance Assessment                                                                  |  | Compliant<br>Temporary Compliance<br>Non-compliant       |  |

All vaccination  
entries require a  
GP signature and  
clinic stamp.



# Example Vaccination Record Card

## Vaccination Record Card for Category A Workers and Students



### INSTRUCTIONS

- Enough information must be provided to enable an assessor to verify that an appropriate vaccine has been administered by a registered vaccination provider therefore:
- Providers should record their full name, signature, date specific vaccine given and official provider stamp at the time of vaccine administration.
  - Batch numbers should be recorded where possible.
  - Serological results should be recorded on the card as numerical values or positive/negative, as appropriate, not simply "immune".
  - Copies of vaccination records (e.g. childhood vaccinations) and copies of relevant pathology reports may be attached to the card, if available.
  - Attach another card if additional recording space is required.

### Evidence required for Category A Staff

| Disease                                                              | Evidence of vaccination                                                                                                                                                                                                                                                          | Documented serology results                                                                                                                                                                  | Notes                                                                                                                                                                                                                   |
|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| COVID-19                                                             | <input checked="" type="checkbox"/> AIR Immunisation history statement or AIR COVID-19 digital certificate<br><b>OR</b><br>Evidence of a temporary or permanent medical contraindication – Australian Immunisation Register (AIR) – immunisation medical exemption form (IM011). | Not applicable                                                                                                                                                                               |                                                                                                                                                                                                                         |
| Diphtheria, tetanus, pertussis (whooping cough)                      | <input checked="" type="checkbox"/> One adult dose of pertussis containing vaccine (dTpa) <sup>1</sup> within the last 10 years.<br><b>Do not use ADT vaccine as it does not contain the pertussis component</b>                                                                 | Serology must not be accepted                                                                                                                                                                |                                                                                                                                                                                                                         |
| Hepatitis B                                                          | <input checked="" type="checkbox"/> History of completed age-appropriate course of hepatitis B vaccine<br>Adolescent course: two doses of adult vaccine, given 4 to 6 months apart, between 11-15 years of age<br><b>Not "accelerated" course</b>                                | <input checked="" type="checkbox"/> Anti-HBs greater than or equal to 10mIU/mL<br><b>AND</b><br>Serology must be at least 4 weeks after the final booster, of a completed hepatitis B course | <input type="checkbox"/> Documented evidence of anti-HBc, indicating past hepatitis B infection, and/or HBsAg+<br><b>OR</b>                                                                                             |
| Measles, mumps, rubella (MMR)                                        | <input type="checkbox"/> 2 doses of MMR vaccine at least one month apart                                                                                                                                                                                                         | <input checked="" type="checkbox"/> Positive IgG for measles, mumps and rubella <sup>2</sup><br><b>OR</b>                                                                                    | <input type="checkbox"/> Birth date before 1966<br><b>OR</b>                                                                                                                                                            |
| Varicella (chickenpox)                                               | <input type="checkbox"/> 2 doses of varicella vaccine at least one month apart (evidence of one dose is sufficient if the person was vaccinated before 14 years of age)                                                                                                          | <input checked="" type="checkbox"/> Positive IgG for varicella <sup>3</sup><br><b>OR</b>                                                                                                     | <input type="checkbox"/> An Australian Immunisation Register (AIR) history statement that records natural immunity to chickenpox can also be accepted as evidence of compliance for varicella <sup>3</sup><br><b>OR</b> |
| Tuberculosis (TB)<br><br>* For those assessed as requiring screening | Not applicable                                                                                                                                                                                                                                                                   | <input checked="" type="checkbox"/> Interferon Gamma Release Assay (IGRA)<br>+ Clinical review for positive results by TB Service/Chest Clinic                                               | <input type="checkbox"/> Tuberculin skin test (TST)<br><b>OR</b><br>+ Clinical review for positive results by TB Service/Chest Clinic                                                                                   |
| Influenza vaccine                                                    | <input type="checkbox"/> One dose of current southern hemisphere seasonal influenza vaccine by 1 June each year                                                                                                                                                                  | Not applicable                                                                                                                                                                               |                                                                                                                                                                                                                         |

\*TB screening (TST or IGRA) required if the person was born in a country with high incidence of TB, or has resided or travelled for a cumulative time of 3 months or longer in a country with a high incidence of TB, as listed at: [www.health.nsw.gov.au/Infectious/tuberculosis/Pages/high-incidence-countries.aspx](http://www.health.nsw.gov.au/Infectious/tuberculosis/Pages/high-incidence-countries.aspx)

<sup>1</sup> Serology must not be performed to detect pertussis immunity.

<sup>2</sup> Serology is only required for MMR protection if vaccination records are not available and the person was born during or after 1966.

<sup>3</sup> A verbal history of Varicella disease must not be accepted.