

Monash Immunisation Services

293 Springvale Road (PO Box 1)
GLEN WAVERLEY 3150
Telephone 95183539 or 95183540 Fax.95183444



REQUEST AND CONSENT FOR VARICELLA (CHICKEN POX)

Family Name:..... Given Name:.....
Address: Postcode:.....
Telephone Number: Date of Birth:

I request that I/my child receive/s a **(course/ single dose)** of Varicella vaccine.

I have read the attached information on Varicella immunisation.

Signature:

FEE PAYABLE FOR VARICELLA IMMUNISATION

Varicella vaccine

\$50.00 per dose

Amount to be paid:

\$.....

Attachment:

Office Use Only	
Account No.1.60.610.5125.000.3206	
Description:	Varicella Vaccine
Date Paid:	
Receipt No:	
ImPS No:	

PLEASE BRING YOUR RECEIPT TO THE IMMUNISATION SESSION