

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to [Section H](#) of the Pharmaceutical Schedule. For community funding, see the [Special Authority Criteria](#).

PRESCRIBER

Name:

Ward:

PATIENT:

Name:

NHI:

COVID-19 vaccine

INITIATION – initial dose

Prerequisites (tick box where appropriate)

- ☐ Up to three doses for previously unvaccinated children aged 6 months – 4 years at high risk of severe illness

I confirm that the above details are correct:

Signed: Date: