

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 or highly immunocompromised

**CONTINUATION – additional dose**

**Prerequisites** (tick boxes where appropriate)

- One additional dose with the most current variant-matched vaccine every 6 months for highly immunocompromised children aged 6 months to 4 years
- or
- One additional dose with the most current variant-matched vaccine every 12 months for children aged 6 months to 4 years old at high risk of severe illness

I confirm that the above details are correct:

Signed: ..... Date: .....