Immunisation Consent Form 2024/2025 for students starting Junior Infants Measles, Mumps, Rubella (MMR) and Diphtheria, Polio, Tetanus, Whooping Cough (Pertussis) (4 in 1)

Junior Infants

COMPLETE THE FORM IN BLOCK CAPITALS USING A PEN.

Please complete the details in Parts 1-4. Please complete this consent form and return it in the envelope provided before the vaccinations begin.

Part 1: Student Personal Details

Complete this part for all students (PLEASE US	E BLUCK CA	PITAL3)
Student Forename: Student	t Middle Name:	
Student Surname (Family Name):		
Otherwise known as:	immmh	
Personal Public Services Number (PPSN):		
Date of Birth:		Sex at birth: Male Female
D D M M Y Y Y		
Mother's surname at birth:		
Address:		
Eircode:		
County:		
Student's Address when they last had a vaccine:		
Student's ethnic or cultural background:		
A. White C. Asian or Asian Irish		D.3 Other, write in description
A.1 Irish C.1 Chinese		Description
A.2 Irish Traveller C.2 Indian/Pakistani/E		
A.3 Roma C.3 Any other Asian b		
Any other Asian b	ackground	E. Prefer not to sav
A.4 Any other White background D. Other, including mixed	_	E. Prefer not to say
Any other White background	_	E. Prefer not to say
A.4 Any other White background D. Other, including mixed	background	E. Prefer not to say
A.4 Any other White background D. Other, including mixed B. Black or Black Irish D.1 Arab	background	E. Prefer not to say
A.4 Any other White background D. Other, including mixed B. Black or Black Irish D.1 Arab D.2 Mixed, write in de	background	E. Prefer not to say
A.4 Any other White background D. Other, including mixed B. Black or Black Irish B.1 African B.2 Any other Black background D. Other, including mixed D.1 Arab D.2 Mixed, write in de Description	background	E. Prefer not to say
A.4 Any other White background B. Black or Black Irish B.1 African B.2 Any other Black background D. Other, including mixed D.1 Arab D.2 Mixed, write in de Description Student's Country of Birth:	background	E. Prefer not to say
A.4 Any other White background B. Black or Black Irish B.1 African B.2 Any other Black background Student's Country of Birth: Class: D. Other, including mixed D. Other, includi	background	E. Prefer not to say
A.4 Any other White background B. Black or Black Irish B.1 African B.2 Any other Black background Student's Country of Birth: Class: Year: D. Other, including mixed D. Other,	background	E. Prefer not to say
A.4 Any other White background B. Black or Black Irish B.1 African B.2 Any other Black background Student's Country of Birth: Class: Year:	background	E. Prefer not to say
A.4 Any other White background B. Black or Black Irish B.1 African B.2 Any other Black background Student's Country of Birth: Class: Year: D. Other, including mixed D. Other,	background	E. Prefer not to say
A.4 Any other White background B. Black or Black Irish B.1 African B.2 Any other Black background Student's Country of Birth: Class: Year: Class Name OR Number OR Letter:	background	E. Prefer not to say

Part 2: Parent/Guardian Personal Details

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mail:				İ																		İ					
this your child's first ye	ar in J	unic	r In	fants	?																		Υe	es		No	
If you tick yes to any you to discuss further email.																											
PART 3:														e	t	a		S Yes		N	lo		Do) No	t Kr	now	
as this student received																	,	Yes		Ν	lo	Ī	Do	No	t Kr	now	Г
as this student had any	vaccir	nes i	n th	ne pa	ast 6	3 m	onth	ns?															Ye	es		No	
lease detail																											
as this student already	had a s	seco	ond	MM	R va	acc	ine i	for t	rav	el/o	utbr	eak	?										Ye	es		No	
ease detail																											
as this student had any	seriou	s illı	ness	s?																			Υe	es		No	
ease detail																											
this student currently to	aking r	ned	icat	ion?																			Υe	es		No	
lease detail																											
as this student ever had r vaccines?					(inc	cluc	ding	ana	aph	/lax	is) to	o ar	nyth	ing	incl	udi	ng r	ned	icat	ion			Ye	es [No	
lease detail																											
oes this student have a	ny illne	ess c	or co	ondit	ion	tha	at in	crea	ses	the	eir ri	sk c	of bl	eec	lingʻ	?							Ye	es		No	
lease detail																											

Part 4: Immunisation Consent

Class:

Medical Consent: Please note only a parent or legal guardian can provide consent for a medical procedure for young people under 16 years of age. Young people aged consent for themselves. Read more about the <u>HSE Consent Policy</u> on the HSE websit	16 years or older are legally en	
CONSENT TO VACCINATION: Please tick the box for each vaccine indicating whether you consent (tick yes) or refus		ection.
MMR Yes No		
4-in-1 Yes No		
I have read and understand the accompanying vaccine information, including known	side effects.	
I confirm by signing this form that I am authorised to give or refuse consent on behalf of the	above named student.	
Name (Please print):		
(Please tick): Parent Legal Guardian Self		
Signature: Date: D D M M Y Y Y Y		
Thank you for completing the consent form. Please return	in the envelope prov	/ided.
Privacy Notice: The HSE do not use consent as a lawful basis for processing perso to explain how we collect and use personal information the HSE provides details wit and Service Users which is accessible via the HSE Privacy Statement. The processing fair. It will only be processed for specific purposes including, to manage the vaccinate programmes, to validate clients and provide health care. Data sharing between HSE	thin the <u>HSE Privacy Notice for</u> ing of your child's data will be lations, to report and monitor var	Patients awful and
FOR OFFICE USE ONLY		
	D. CELL	
Name:	Date of Birth:	

School Roll Number:

PID:

For Office Use Only

Administration Details:

Class:

Date Given Batch No. Expiry Date Prescriber's signature and MCRN/PIN Prescriber's signature and MCRN/P	tarring tractor betails.					
Date Given Batch No. Expiry Date Prescriber's signature and MCRN/PIN Prescriber's signature and MCRN/P	This young person assents	to receiving the	vaccine (Please	tick)		
Ime Vaccinated: AM/PM Vaccination Location: School Clinic Clinic Name: Vaccination Location: School Clinic Clinic Name: Vaccination Location: School Clinic Name: Vaccinator's signature Vaccinator's signature and MCRN/PIN Name (Clinic Name: School Clinic Name: School Clinic Name: Name (Clinic Name: Name) AM/PM Vaccination Location: School Clinic Name: School Clinic Name: Name (Clinic Name: Name) MCRN/PIN: MCRN/PIN: MCRN/PIN: MCRN/PIN: D D M M Y Y Y DNA or Absent Refused on the Day Cone Contraindicated Deferred Other Other Other Refused on the Day Cone Contraindicated Deferred Other Other Refused Name:		Batch No.	Expiry Date			(Circle as
This young person assents to receiving the vaccine (Please tick) Date Given			M M Y Y Y			Deltoid Deltoid
Date Given Batch No. Expiry Date Prescriber's signature Vaccinator's signature of MCRN/PIN and MCRN/PIN Right Delto MCRN/PIN: MCRN/PIN: MCRN/PIN: MCRN/PIN: D D M M Y Y Y Avaccine not administered please state why? Coine Contraindicated Deferred Other Other Refused on the Day Otes/Comments:	Гіme Vaccinated:	AM/PM				ne:
Date Given Batch No. Expiry Date and MCRN/PIN and MCRN/PIN appropriate appropr	This young person assents	to receiving the	vaccine (Please	tick)		
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me: Date of Birth:	OR OFFICE USE ONLY					
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School Roll Number:

PID: