Immunisation History and Consent Form

Checklist and consent form to vaccinate adult and child refugees and applicants seeking protection in Ireland.

(a) primary immunisation and catch-up as recommended in the national immunisaion schedule in Ireland
(b) vaccination in response to a case or outbreak, on the advice of Public Health.

Version 3.0 January 2025

Section 1: Personal Details

Please complete this section for the person being vaccinated (PLEASE USE BLOCK CAPITALS)

Forename: Middle Name:

Surname (Family Name): Otherwise known as:

Personal Public Service Number (PPSN):

Date of Birth: D D M M Y Y Y Y Sex at Birth: Male Female

Address (in Ireland):

County: Eircode:

Ethnic or Cultural Background:

A. White

A.1 Irish

A.2 Irish Traveller

A.3 Roma

A.4 Any other White background

B. Black or Black Irish

B.1 African

B.2 Any other Black background

C. Asian or Asian Irish

C.1 Chinese

C.2 Indian/Pakistani/Bangladeshi

C.3 Any other Asian background

D. Other, including mixed background

D.1 Arab

D.2 Mixed, write in description

Description

D.3 Other, write in description

Description

E. Prefer not to say

Country of Birth: Parent/Guardian Primary Language (if applicable):

Mobile Phone Number: Email Address:

If person for vaccination is 15 years or younger please complete the following:

Mother's Surname at Birth:

Mothers Date of Birth: D D M M Y Y Y Y

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Name: DOB: D D M M Y Y Y Y

HSE Client ID:

Please complete Section 2 **AND** Section 3

Section 2: Medical History

Please complete this section for the child or adult being vaccinated (PLEASE USE BLOCK CAPITALS)

Please answer the following questions with a yes or no answer

Have you/your child any serious illness? Yes No

Please give details

Are you or your child currently taking any medication? Yes No

Please give details

Have you/your child ever had a severe reaction (including anaphylaxis) to anything including medication, vaccines or latex? Yes No

Please give details

Have you/your child had any illness or condition that increases risk of bleeding? Yes No

Please give details

Have you/your child received any vaccines in the past 6 months? Yes No

Please give details

Section 3: Vaccination History

6 in 1 (Diphtheria, Tetanus, Polio, Pertussis [whooping cough], HepB and Hib) vaccine

Has the person being vaccinated ever received any vaccines containing Diphtheria, Tetanus, Polio, Pertussis (whooping cough), HepB or Hib? In Ireland these may be given together as the 6 in 1 vaccine.

Yes No Do Not Know

If yes, what vaccines did your child receive?

How many doses?

At what age did they receive each dose?

MenB (meningococcal B) vaccine

Has the person being vaccinated ever received the MenB vaccine? Yes No Do Not Know

If yes, how many doses?

At what age did they receive each dose?

PCV (pneumococcal) vaccine

Has the person being vaccinated ever received the PCV vaccine? Yes No Do Not Know

If yes, how many doses?

At what age did they receive each dose?

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Name: DOB: D D M M Y Y Y Y

HSE Client ID:

Rotavirus vaccine

Please note this vaccine is NOT recommended on or after 8 months of age

Has your child received any Rotavirus vaccine? Yes ☐ No ☐ Do Not Know ☐

If yes, how many doses? ☐

At what age did they receive each dose?

Does your child have diarrhoea or vomiting at the moment? Yes ☐ No ☐

Has your child been diagnosed with any of the following conditions?

Intussusception Yes ☐ No ☐

An abnormality of the gut (e.g., Meckel's diverticulum) Yes ☐ No ☐

Severe Combined Immunodeficiency (SCID)? Yes ☐ No ☐

Are there any diseases in the family that affect the immune system? Yes ☐ No ☐

Did anyone in either parents' family need a bone marrow transplant aged < 12 months? Yes ☐ No ☐

When/if your baby had their newborn bloodspot screening (heel prick test) was there any follow up needed because of the results of the test? Yes ☐ No ☐

Has your child been diagnosed with any of the following rare hereditary conditions?

Fructose intolerance Yes ☐ No ☐

Sucrose-isomaltase deficiency Yes ☐ No ☐

Glucose-galactose malabsorption Yes ☐ No ☐

If you have answered yes to any of these conditions, please provide details

Did this child's mother take a medication called infliximab during her pregnancy and/or when breastfeeding? Yes ☐ No ☐

Please provide details

MenC (Meningococcal C) vaccine

Has the person being vaccinated ever received the MenC vaccine? Yes ☐ No ☐ Do Not Know ☐

If yes, how many doses? ☐

At what age did they receive each dose?

MMR (measles, mumps and rubella) vaccine

Has the person being vaccinated ever received the MMR or any other measles or rubella vaccine?

Yes ☐ No ☐ Do Not Know ☐

If yes, how many doses? ☐

At what age did they receive each dose?

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Name: DOB: D D M M Y Y Y Y

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4 in 1 (Diphtheria, tetanus, polio, pertussis [whooping cough]) vaccine

Has the person being vaccinated received any vaccines containing Diphtheria, Tetanus, Polio, or Pertussis (whooping cough)? In Ireland these may be given together as the 4 in 1 vaccines?

Yes ☐ No ☐ Do Not Know ☐

If yes at what age did they receive each vaccine?

Has your child completed, or is currently in junior infant's class in Ireland? Yes ☐ No ☐

Has your child received any vaccines in primary school in Ireland or elsewhere? Yes ☐ No ☐

If yes, please list the vaccines and at what age they received each dose

Hib (Haemophilus influenzae b) Vaccine

Has the person being vaccinated ever received the Hib vaccine? Yes ☐ No ☐ Do Not Know ☐

If yes, how many doses?

At what age did they receive each dose?

Tdap (Tetanus Diphtheria Pertussis [whooping cough]) vaccine

Has the person being vaccinated ever received the Tdap vaccine? Yes ☐ No ☐ Do Not Know ☐

If yes, how many doses?

At what age did they receive each dose?

Please only complete this next section if your child was born on or after October 1st 2024

Varicella (Chickenpox) vaccine

Has your child received a Chickenpox vaccine at 12 months or older? Yes ☐ No ☐ Do Not Know ☐

If yes, how many doses?

At what age did they receive each dose?

If no, has your child ever:

Had tuberculosis (TB)? Yes ☐ No ☐

Received a blood transfusion or any other blood product? Yes ☐ No ☐

Had treatment with antivirals e.g. acyclovir in the previous 24 hours? Yes ☐ No ☐

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Name: DOB: D D M M Y Y Y Y

HSE Client ID:

Please go to Section 5 to complete consent form for vaccination

Section 5: Consent

Medical Consent: Please note only a parent or legal guardian can provide consent for a medical procedure, or refuse consent for a medical procedure for young people under 16 years of age. Young people aged 16 years or older are legally entitled to consent for themselves. Read more about the HSE Consent Policy on the HSE website: https://bit.ly/ConsentU16

Please indicate the vaccine(s) for which you are providing consent to receive. Your vaccinator will tell you which vaccines are required, and how many doses are needed:

- ☐ 6 in 1 vaccine (DTaP/Hib/IPV/Hep B)
- ☐ MenC (Meningococcal C)
- ☐ Rotavirus (Rotavirus oral vaccine)
- ☐ Hib (Haemophilus influenza b)
- ☐ Tdap/IPV
- ☐ Td/IPV
- ☐ MenB (Meningococcal B)
- ☐ PCV (Pneumococcal conjugate)
- ☐ MMR (Measles, Mumps and Rubella)
- ☐ 4 in 1 (DTaP/IPV)
- ☐ Tdap
- ☐ Varicella

I understand the accompanying vaccine information, including known vaccine side effects. ☐

I understand that MMR vaccine is not recommended during pregnancy and that pregnancy should be avoided for 4 weeks after MMR vaccination. ☐

I understand that varicella (chickenpox) vaccine is not recommended during pregnancy and that pregnancy should be avoided for 4 weeks after varicella (chickenpox) vaccination. ☐

If a parent or legal guardian providing consent for someone under 16 years of age:
I confirm by signing this form that I am authorised to give consent on behalf of the above named child.

Signature: _____ Consent Date: _____

For those aged 16 years and older:
I confirm that I consent to vaccination

Signature: _____ Consent Date: _____

Privacy Statement: *The HSE do not use consent as a lawful basis for processing personal data. In the interest of transparency, to explain how we collect and use personal information the HSE provides details within the HSE Privacy Notice for Patients and Service Users which is accessible via the HSE Privacy Statement. The processing of your child's data will be lawful and fair. It will only be processed for specific purposes including, to manage the vaccinations, to report and monitor vaccination programmes, to validate clients and provide health care. Data sharing between HSE departments may also occur.*

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Name: _____ DOB: D D M M Y Y Y Y

HSE Client ID: _____

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Date given: / / Time given: :	Vaccine:	Dose No:	Batch No:	Expiry Date:	Prescribers signature and MCRN/PIN:	Vaccinators signature and MCRN/PIN:	Injection Site:
Date given: / / Time given: :							
Date given: / / Time given: :							
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Name: DOB: D D M M Y Y Y Y

HSE Client ID: