For official use only

Class: School Roll Number: Client ID:

Name: Date of Birth:

Vaccination consent form for second level schools

This consent form needs to be completed to give consent for

- 2/3 doses of HPV vaccine (Human papillomavirus vaccine)
- 1 dose of Tdap vaccine (tetanus, diphtheria and pertussis (whooping cough) vaccine)
- 1 dose of MenC (meningitis) vaccine (meningococcal C vaccine)

These vaccines will be given during the school year.

It is planned that 2 vaccines will be given at each school visit; however note that this may vary in some circumstances for some pupils.

Visit 1: HPV (Dose one) + Tdap	**Visit 2:** HPV (Dose two) + MenC

For each vaccination where you wish to give consent please fill and sign Parts 1 and 2.

For each vaccination where you wish to refuse consent please fill and sign Parts 1 and 3.

Please note only a parent or legal guardian can consent or refuse consent for students. Students over 16 years of age are legally entitled to consent for themselves.

Complete the form in Block CAPITALS using a pen.

Return this form before the vaccinations or within 7 days even if you do not consent.

Privacy Statement: HSE staff are aware of their obligation under the Data Protection Acts, 1988-2018 (including GDPR). The information provided will be included in an Immunisation Database. The HSE will use this information to validate clients, monitor vaccination programmes and to provide health care. The data for HPV vaccine will be made available to CervicalCheck – The National Cervical Screening Programme for use in the context of its service.

Notes/Comments: (For office use only)

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Class: School Roll Number: Client ID:

Personal Details

PART 1 Complete this part for all students (PLEASE USE BLOCK CAPITALS)

Student's Forename: Student's Middle Name:

Student's Surname (Family Name): Otherwise known as:

Student's Personal Public Services Number (PPSN):
(PPSN will be required to manage your immunisation record only)

Sex: Male Female

Student's Date of Birth: D D M M Y Y Y Y Student's Surname at Birth:

Mother's Maiden Name: Mother's Date of Birth: D D M M Y Y Y Y

(This information may be required to manage your child's immunisation services)

Student's Address:

County:

Student's Home Address at Birth:

Parent/Legal Guardian Forename and Surname:

Daytime Contact Phone No.: Mobile Phone No.:

Do you consent to receiving vaccine related texts? Yes No

School/College Name: Class: Year:

GP Name and Address:
(Your information may be shared with your General Practitioner)

1. Has this student previously received HPV vaccine? Yes No
2. Has this student had any serious illness in recent years? Yes No

   Please detail:
3. Are they currently taking medication? Yes No

   Please detail:
4. Has this student ever had a severe reaction to **anything** including medication or vaccine (including anaphylaxis)? Yes No

   Please detail:
5. Do they have any illness or condition that increases their risk of bleeding? Yes No

   Please detail:

Please go to page 3 to give or refuse consent ▶

Name: Date of Birth:

Choose Part 2 (YES) **OR** Part 3 (NO) for **EACH VACCINE**

PART 2 — Please tick the box for the vaccine/s you consent to and sign to say **YES**

Yes, I consent to the vaccination of the above named student with **HPV** vaccine. ☐

Yes, I consent to the vaccination of the above named student with **Tdap** vaccine. ☐

Yes, I consent to the vaccination of the above named student with **MenC** vaccine. ☐

- I have read and understand the accompanying vaccine information, including known side effects.
- I understand that HPV vaccine is not recommended during pregnancy.
- I understand that I am giving consent for the administration of 2/3 doses of HPV vaccine over 6 to 12 months.
- I confirm by signing this form that I am authorised to give consent on behalf of the above named student. (Students over 16 years of age are legally entitled to consent for themselves)

Signature: ____________________ Consent Date: D D M M Y Y Y Y

Name (Please print): ____________ (Please tick): Parent ☐ Legal Guardian ☐ Self ☐

OR

PART 3 — Please tick the box for the vaccine/s you do not consent to and sign to say **NO**

No, I do not consent to the vaccination of the above named student with **HPV** vaccine. ☐

No, I do not consent to the vaccination of the above named student with **Tdap** vaccine. ☐

No, I do not consent to the vaccination of the above named student with **MenC** vaccine. ☐

- I have read and understand the accompanying vaccine information, including known side effects.
- I confirm by signing this form that I am authorised to refuse consent on behalf of the above named student. (Students over 16 years of age are legally entitled to consent for themselves)

Signature: ____________________ Date: D D M M Y Y Y Y

Name (Please print): ____________ (Please tick): Parent ☐ Legal Guardian ☐ Self ☐

Reason for Refusal: ______________________________

Name: Date of Birth:

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If vaccine not administered please state why? Absent ☐ Contraindicated ☐ Deferred ☐ DNA ☐
Referred to hospital setting ☐ Refused ☐ Other ☐

Completed by: ______________ **MCRN/PIN:** (if applicable) ______________ D D M M Y Y Y Y

HPV Dose	Date Given	Batch Number	Injection Site (Circle as appropriate)		Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN
1	/ /		Right Deltoid	Left Deltoid		
Time Vaccinated:			**AM / PM**		Vaccination Location:	School ☐ Clinic ☐
Clinic Name:						

If vaccine not administered please state why? Absent ☐ Contraindicated ☐ Deferred ☐ DNA ☐
Referred to hospital setting ☐ Refused ☐ Other ☐

Completed by: ______________ **MCRN/PIN:** (if applicable) ______________ D D M M Y Y Y Y

HPV Dose	Date Given	Batch Number	Injection Site (Circle as appropriate)		Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN
2	/ /		Right Deltoid	Left Deltoid		
Time Vaccinated:			**AM / PM**		Vaccination Location:	School ☐ Clinic ☐
Clinic Name:						

If vaccine not administered please state why? Absent ☐ Contraindicated ☐ Deferred ☐ DNA ☐
Referred to hospital setting ☐ Refused ☐ Other ☐

Completed by: ______________ **MCRN/PIN:** (if applicable) ______________ D D M M Y Y Y Y

HPV Dose	Date Given	Batch Number	Injection Site (Circle as appropriate)		Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN
3	/ /		Right Deltoid	Left Deltoid		
Time Vaccinated:			**AM / PM**		Vaccination Location:	School ☐ Clinic ☐
Clinic Name:						

If vaccine not administered please state why? Absent ☐ Contraindicated ☐ Deferred ☐ DNA ☐
Referred to hospital setting ☐ Refused ☐ Other ☐

Completed by: ______________ **MCRN/PIN:** (if applicable) ______________ D D M M Y Y Y Y

MenC Dose	Date Given	Batch Number	Injection Site (Circle as appropriate)		Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN
	/ /		Right Deltoid	Left Deltoid		
Time Vaccinated:			**AM / PM**		Vaccination Location:	School ☐ Clinic ☐
Clinic Name:						

If vaccine not administered please state why? Absent ☐ Contraindicated ☐ Deferred ☐ DNA ☐
Referred to hospital setting ☐ Refused ☐ Other ☐

Completed by: ______________ **MCRN/PIN:** (if applicable) ______________ D D M M Y Y Y Y

Tdap Dose	Date Given	Batch Number	Injection Site (Circle as appropriate)		Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN
	/ /		Right Deltoid	Left Deltoid		
Time Vaccinated:			**AM / PM**		Vaccination Location:	School ☐ Clinic ☐
Clinic Name:						