FOR OFFICE USE ONLY

Class: School Roll Number: Client ID:

Name: Date of Birth:

Vaccination Consent Form

for children starting Junior Infants

Measles, Mumps, Rubella (MMR) and **Diphtheria, Polio, Tetanus, Whooping Cough (Pertussis)** (4 in 1)

If you wish to give consent please fill in Parts 1 & 2. If you do not wish to give consent please fill in parts 1 & 3. (Parts 2 & 3 are overleaf). Please note only a parent or legal guardian can consent or refuse consent for students. Please return form to your school as soon as possible in the envelope provided.

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 provide health care.

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

Child's Forename: Child's Middle Name:

Child's Surname (Family Name):

Otherwise known as:

Child's Personal Public Services Number (PPSN):

(PPSN will be required to manage your immunisation record only)

Email:

Do you consent to receive emails about vaccine appointments? Yes No

Child's Date of Birth: D D M M Y Y Y Y Child's Gender: Male Female

Mother's Maiden Name:

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

Child's Address:

Eircode: County:

Child's Address when they last had a vaccine:

Parent/Legal Guardian Forename and Surname:

Daytime Phone Number:

Mobile Phone Number:

Do you consent to receive texts about vaccine appointments? Yes No

School:

Class: Year:

Please turn over

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Class: _____ School Roll Number: _____ Client ID: _____

Name: _____ Date of Birth: _____

Is this your child's first year in Junior Infants? Yes ☐ No ☐

Has this child received their routine vaccines due at 2, 4 and 6 months? Yes ☐ No ☐ Do Not Know ☐

Has this child received their first MMR vaccine due at 12 months? Yes ☐ No ☐ Do Not Know ☐

Has this child had any vaccines in the past 6 months? Yes ☐ No ☐

Please detail _____

Has your child already had a second MMR vaccine for travel/outbreak? Yes ☐ No ☐

Please detail _____

Has this child had any serious illness? Yes ☐ No ☐

Please detail _____

Is this child currently taking medication? Yes ☐ No ☐

(Include ointments/creams that affect the immune system e.g. Protopic cream)

Please detail _____

Has this child ever had a severe reaction to **anything** including medication or vaccines? Yes ☐ No ☐

(including anaphylaxis)

Please detail _____

Does this child have any illness or condition that increases their risk of bleeding? Yes ☐ No ☐

Please detail _____

PART 2 Please sign these boxes to say **Yes**

Sign this box if you do wish to give consent for MMR

Yes, I consent to have the above named child vaccinated to protect against **Measles, Mumps and Rubella (MMR)**. 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 consent on behalf of the above named child.

Signature: _____

(Parent/Legal Guardian)

My Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date: ☐☐ ☐☐ ☐☐☐☐
D D M M Y Y Y Y

Please print

Sign this box if you do wish to give consent for 4 in 1

Yes, I consent to have the above named child vaccinated to protect against **Diphtheria, Polio Tetanus and Whooping Cough (4 in 1)**. 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 consent on behalf of the above named child.

Signature: _____

(Parent/Legal Guardian)

My Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date: ☐☐ ☐☐ ☐☐☐☐
D D M M Y Y Y Y

Please print

FOR OFFICE USE ONLY

Class: School Roll Number: Client ID:

Name: Date of Birth:

PART 3 Please sign these boxes to say **No**

Sign this box if you do not wish to give consent for MMR

No, I do not consent to have the above named child vaccinated to protect against **Measles, Mumps and Rubella (MMR)**. I have read and understand the accompanying vaccine information, including risks of not vaccinating. I confirm by signing this form that I am authorised to refuse consent on behalf of the above named child.

Signature:

(Parent/Legal Guardian)

My Name: Date: D D M M Y Y Y Y

Please print

Reason for refusal:

Sign this box if you do not wish to give consent for 4 in 1

No, I do not consent to have the above named child vaccinated to protect against **Diphtheria, Polio, Tetanus and Whooping Cough (4 in 1)**. I have read and understand the accompanying vaccine information, including risks of not vaccinating. I confirm by signing this form that I am authorised to refuse consent on behalf of the above named child.

Signature:

(Parent/Legal Guardian)

My Name: Date: D D M M Y Y Y Y

Please print

Reason for refusal:

For Office Use Only Administration Details:

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

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

If vaccine not administered please state why? DNA or Absent Refused on the Day

Vaccine Contraindicated Deferred Other

Completed by: **MCRN/PIN:** D D M M Y Y Y Y

(if applicable)

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Class: School Roll Number: Client ID:

Name: Date of Birth:

For official use only

Notes/Comments:

Junior Infants