

## Junior Infants

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

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

PID:

## Part 2: Parent/Guardian Personal Details

Parent/Legal Guardian Forename and Surname:

[illegible]

Daytime Phone Number:

[illegible]

Mobile Phone Number:

[illegible]

Email:

[illegible]

Is this your child's first year in Junior Infants?

Yes ☐ No ☐

**If you tick yes to any of the Student Medical Details in Part 3 the Schools Immunisation Team may need to contact you to discuss further. Please note we will send you an appointment confirmation and/or reminders by SMS and/or email.**

## PART 3: Student Medical Details

Has this student received their routine vaccines due at 2, 4 and 6 months?

Yes ☐ No ☐ Do Not Know ☐

Has this student received their first MMR vaccine due at 12 months?

Yes ☐ No ☐ Do Not Know ☐

Has this student had any vaccines in the past 6 months?

Yes ☐ No ☐

Please detail

Has this student already had a second MMR vaccine for travel/outbreak?

Yes ☐ No ☐

Please detail

Has this student had any serious illness?

Yes ☐ No ☐

Please detail

Is this student currently taking medication?

Yes ☐ No ☐

Please detail

Has this student ever had a severe reaction (including anaphylaxis) to anything including medication or vaccines?

Yes ☐ No ☐

Please detail

Does this student have any illness or condition that increases their risk of bleeding?

Yes ☐ No ☐

Please detail

**FOR OFFICE USE ONLY**

Name:

\_\_\_\_\_

Date of Birth:

\_\_\_\_\_

Class:

\_\_\_\_\_

School Roll Number:

\_\_\_\_\_

PID:

\_\_\_\_\_

## Part 4: Immunisation 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.

### CONSENT TO VACCINATION:

Please tick the box for each vaccine indicating whether you consent (tick yes) or refuse (tick no), and then sign the section.

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:   
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Thank you for completing the consent form. Please return in the envelope provided.

**Privacy Notice:** 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.

### FOR OFFICE USE ONLY

Name:  Date of Birth:   
Class:  School Roll Number:  PID:

# For Office Use Only

## Administration Details:

This young person assents to receiving the vaccine (Please tick) ☐

MMR	Date Given	Batch No.	Expiry Date	Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Injection Site (Circle as appropriate)			
	<div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>		<div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>			<div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div><div>Right</div><div>Deltoid</div></div>
Time Vaccinated: <div>AM/PM</div>				Vaccination Location: School <input type="checkbox"/> Clinic <input type="checkbox"/>		Clinic Name:			

This young person assents to receiving the vaccine (Please tick) ☐

4 in 1	Date Given	Batch No.	Expiry Date	Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Injection Site (Circle as appropriate)		
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Time Vaccinated: <div>AM/PM</div>				Vaccination Location: School <input type="checkbox"/> Clinic <input type="checkbox"/>		Clinic Name:		

Completed by: \_\_\_\_\_ MCRN/PIN: \_\_\_\_\_ 

D

D

M

M

Y

Y

Y

Y

If vaccine not administered please state why?  
Vaccine Contraindicated ☐ Deferred ☐ Other

DNA or Absent ☐ Refused on the Day ☐

## Notes/Comments:

FOR OFFICE USE ONLY

Name:

Date of Birth:

Class:

School Roll Number:

PID: