VISIT 1 HPV (Dose one) + Tdap + MenACWY

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

HPV Dose	Date Given	Batch No.	Expiry Date	Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Injection Site (Circle as appropriate)	
1	D D M M Y Y Y Y		M M Y Y Y Y			Right Deltoid	Left Deltoid

Time Vaccinated: **AM/PM** Vaccination Location: School ☐ Clinic ☐ Clinic Name:

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

Tdap Dose	Date Given	Batch No.	Expiry Date	Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Injection Site (Circle as appropriate)	
	D D M M Y Y Y Y		M M Y Y Y Y			Right Deltoid	Left Deltoid

Time Vaccinated: **AM/PM** Vaccination Location: School ☐ Clinic ☐ Clinic Name:

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

Men-ACWY Dose	Date Given	Batch No.	Expiry Date	Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Injection Site (Circle as appropriate)	
	D D M M Y Y Y Y		M M Y Y Y Y			Right Deltoid	Left Deltoid

Time Vaccinated: **AM/PM** Vaccination Location: School ☐ Clinic ☐ Clinic Name:

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

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

Vaccine Contraindicated ☐ Deferred ☐ Other _____

VISIT 2 HPV (Dose two) if immunocompromised

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

HPV Dose	Date Given	Batch No.	Expiry Date	Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Injection Site (Circle as appropriate)	
2	D D M M Y Y Y Y		M M Y Y Y Y			Right Deltoid	Left Deltoid

Time Vaccinated: **AM/PM** Vaccination Location: School ☐ Clinic ☐ Clinic Name:

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

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

Vaccine Contraindicated ☐ Deferred ☐ Other _____

VISIT 3 HPV (Dose three) if immunocompromised

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

HPV Dose	Date Given	Batch No.	Expiry Date	Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Injection Site (Circle as appropriate)	
3	D D M M Y Y Y Y		M M Y Y Y Y			Right Deltoid	Left Deltoid

Time Vaccinated: **AM/PM** Vaccination Location: School ☐ Clinic ☐ Clinic Name:

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

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

Vaccine Contraindicated ☐ Deferred ☐ Other _____

FOR OFFICE USE ONLY

Name: _____ Date of Birth: _____ School Name: _____

Class: _____ School Roll Number: _____ PID: _____

Vaccine Consent Form 2025/2026

for students starting 1st Year of secondary school **HPV, Tdap** and **MenACWY** vaccines

First Year

COMPLETE THE FORM IN BLOCK CAPITALS USING A PEN.

Please complete this form to indicate your consent or refusal for the specified vaccines. If you DO wish to give consent, please fill in parts 1- 4. If you DO NOT wish to give consent, please fill in parts 1,2, and 4. Please return it in the envelope provided before the vaccinations begin.

Part 1: Student Personal Details

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

Student Forename: _____ Student Middle Name: _____

Student Surname (Family Name): _____

Otherwise known as: _____

Personal Public Services Number (PPSN): _____

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

Address: _____

Eircode: _____ County: _____

Student's Address when they last had a vaccine [if different than above]: _____

Student's Country of Birth: _____

School/College Name: _____

Year: _____ Class: _____

Has your child been in First Year before? Yes ☐ No ☐

Student's 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 ☐

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Name:

Date of Birth:

School Name:

Class:

School Roll Number:

PID:

Part 2: Parent/Guardian Personal Details

Parent/Legal Guardian Forename and Surname:

Mother's family name at birth [Maiden Name]:

Mobile Phone Number:

Alternate Phone Number:

Email:

The Schools Immunisation Team may need to contact you to discuss details provided in this form. Please note, we may send you an appointment confirmation and/or reminders by SMS and/or email.

PART 3: Student Medical Details

1. Has this student previously received HPV, MenACWY, or Tdap Vaccine? Yes No
If yes, please include details/a copy of their vaccine records with the returned consent form.

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

3. Is the student currently taking any medication? Yes No

Please detail

4. Does the student have any illness or condition that increases their risk of bleeding? Yes No

Please detail

5. Students who have a weak immune system may need 3 doses of the HPV vaccine over six months. Students with a healthy immune system only need 1 dose of HPV vaccine. If you think this student has any of the conditions listed below please ask their Specialist/Consultant if they require 3 doses of HPV vaccine due to having a weak immune system.

- Haematopoietic stem cell also called stem cell transplant
- Solid organ transplant recipients for example kidney, lung or heart transplant patients or other organ transplant
- HIV infection
- Malignant haematological disorders affecting the bone marrow or lymphatic systems, for example leukaemia, lymphomas, blood dyscrasias
- Non-haematological malignant solid tumours (any cancer and malignancy other than blood cancer or cancer in the lymph system)
- Primary immunodeficiency including Down Syndrome (usually you are born with these conditions with a weak immune system)
- Within two weeks of commencing, on or within three to six months of receiving significant immunosuppressive therapy or medication.

You can ask their Specialist/Consultant to visit www.immunisation.ie for further information to help with this discussion. A Specialist/Consultant will usually warn you the medication weakens your immune response and therefore potentially the response to vaccines. If this student does not have a Specialist/Consultant, you can check with their GP or the school immunisation team.

Please tick 'yes' if this student has been advised that they should have 3 doses of HPV vaccine due to having a weak immune system. Yes

By leaving the box blank you are confirming that the student does not have any of the above conditions that requires them to receive 3 doses of HPV vaccine.

FOR OFFICE USE ONLY

Name:

Date of Birth:

School Name:

Class:

School Roll Number:

PID:

Part 4: Vaccination 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.

HPV	**Yes**	**No**
Tdap	**Yes**	**No**
MenACWY	**Yes**	**No**

By signing the below I confirm that:

- I have read and understand the accompanying vaccine information, including known side effects
- I am authorised to give or refuse consent on behalf of the above named student. (Students 16 years or older are legally entitled to consent for themselves)
- I understand that HPV vaccine is not recommended during pregnancy.
- If giving consent for HPV vaccine, I understand that
  - If the person being vaccinated has a healthy immune system, I am giving consent for the administration of 1 dose of HPV vaccine.
  - If the person being vaccinated has been advised that 3 doses of HPV vaccine are needed, I am giving consent for the administration of 3 doses of HPV vaccine over six months.

Name of person giving consent *(Please print)*:

(Please tick): Parent Legal Guardian Self

Signature:

Date:
D D M M Y Y Y Y

Notes/Comments:
(Please share here if there is any additional information about this student you would like to share with the vaccination team or any comments for their attention):

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.