**For official use only**

Class: School Roll Number: Client ID:

Name: Date of Birth:

# HPV, Tdap and MenC Vaccination Consent Form for Girls

This consent form needs to be completed to give consent for

- 2 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 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 been in 1st year before? Yes ☐ No ☐
2. Has this student previously received HPV vaccine? Yes ☐ No ☐
3. Has this student had any serious illness in recent years? Yes ☐ No ☐
   Please detail: _____
4. Are they currently taking medication? Yes ☐ No ☐
   Please detail: _____
5. Has this student ever had a severe reaction to **anything** including medication or vaccine (including anaphylaxis)? Yes ☐ No ☐
   Please detail: _____
6. 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 doses of HPV 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:

# FOR OFFICE USE ONLY

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

| **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: | | | | | | |

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

| **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: | | | | | | |