FOR OFFICE USE ONLY

Class: | School Roll Number: | Client ID:

Name: | Date of Birth:

Vaccination Consent Form 2022/2023
for children starting 1st Year of secondary school
HPV, Tdap and MenACWY vaccines

This consent form needs to be completed

- 2 doses of **HPV vaccine** (human papillomavirus vaccine)
- 1 dose of **Tdap vaccine** (tetanus, diphtheria and pertussis (whooping cough) vaccine)
- 1 dose of **MenACWY vaccine** (meningococcal ACWY vaccine)

These vaccines will be given during the school year.
2 vaccines will be given at each school visit.

VISIT 1: HPV (Dose one) + Tdap	VISIT 2: HPV (Dose two) + MenACWY

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

COMPLETE THE FORM IN BLOCK CAPITALS USING A PEN.

Please complete this consent form and return it in the envelope provided before the vaccinations begin.

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:

First Year

FOR OFFICE USE ONLY

Name: 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)

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

Mother's Maiden Name:

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

Student's Address:

Eircode: County:

Student'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 ☐

Email:

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

Student's ethnic or cultural background:

A. White *(Irish, Irish traveller, Roma, Ukrainian)* ☐ B. Black or Black Irish *(African, Any other Black background)* ☐

C. Asian or Asian Irish *(Chinese, any other Asian background)* ☐

D. other, including mixed background *(Arabic, any other write in description)* ☐

Description _____

Student's Nationality: _____

Class: Year:

School/College Name:

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 _____

FOR OFFICE USE ONLY

Class: | School Roll Number: | Client ID:

Name: | Date of Birth:

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

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

Yes, I consent to the vaccination of the above named student with:

HPV ☐ **Tdap** ☐ **MenACWY** ☐

- 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 16 years or older are legally entitled to consent for themselves)

Signature: _____ Consent Date: ☐☐ ☐☐ ☐☐☐☐

Signature: _____ D D M M Y Y Y Y

Name *(Please print)*: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(Please tick): Parent ☐ Legal Guardian ☐ Self ☐

PART 3 Please tick the box for each vaccine 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 ☐ **Tdap** ☐ **MenACWY** ☐

- 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 16 years or older are legally entitled to consent for themselves)

Signature: _____ Date: ☐☐ ☐☐ ☐☐☐☐

Signature: _____ D D M M Y Y Y Y

Name *(Please print)*: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(Please tick): Parent ☐ Legal Guardian ☐ Self ☐

Reason for Refusal: _____

FOR OFFICE USE ONLY

Class: | School Roll Number: | Client ID:

Name: | Date of Birth:

FOR OFFICE USE ONLY

VISIT 1 HPV (Dose one) + Tdap

HPV Dose	Date Given	Batch Number	Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN	Injection Site (Circle as appropriate)	
1	D D M M Y Y Y Y				Right Deltoid	Left Deltoid

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

Clinic Name:

Tdap Dose	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:

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

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

Vaccine Contraindicated ☐ Deferred ☐ Other _____

VISIT 2 HPV (Dose two) + MenACWY

HPV Dose	Date Given	Batch Number	Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN	Injection Site (Circle as appropriate)	
2	D D M M Y Y Y Y				Right Deltoid	Left Deltoid

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

Clinic Name:

Men-ACWY Dose	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:

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

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

Vaccine Contraindicated ☐ Deferred ☐ Other _____