**For official use only**

| | | |
|---|---|---|
| Class: | School Roll Number: | Client ID: |
| Name: | | Date of Birth: |

# Vaccination Consent Form for children starting 1st Year of secondary school in September 2019

## 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: (For office use only)**

**For official use only**

Class: School Roll Number: Client ID:

Name: Date of Birth:

# 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:

Child's address when they last had a vaccine:

Parent/Legal Guardian Forename and Surname:

Daytime Contact Phone No.:

Mobile Phone No.:

Do you consent to receiving texts related to vaccination appointments? Yes No

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: _____

Please go to page 3 to give or refuse consent ▶

**For official 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: ☐☐☐☐☐☐☐☐ 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 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: ☐☐☐☐☐☐☐☐ D D M M Y Y Y Y

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

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

Reason for Refusal: _____

_____

_____

_____

**For official use only**

Class: School Roll Number: Client ID:

Name: Date of Birth:

# FOR OFFICE USE ONLY

## VISIT 1

| 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:** _____ (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 | 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: | | | | | | |

| MenACWY 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:** _____ (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 _____