FOR OFFICE USE ONLY				
Class:			Date of Birth:	
Name:	School Roll Number:		Client ID:	
	onsent Form 2 arting 1st Year	·		First
	dap and MenA			Year
<ul> <li>This consent form need</li> <li>1 dose of HPV vaccivaccine (for those w</li> <li>1 dose of Tdap vaccine</li> <li>1 dose of MenACWY</li> </ul>	ds to be completed ne (for those with a healt ith a weak immune syste ine (tetanus, diphtheria ar vaccine (meningococca given during the school y	thy immune sy m) nd pertussis (w I ACWY vaccir	vstem) OR 3 dos	
Students 16 years or olde consent on the HSE web	t or legal guardian can cor er are legally entitled to co site https://bit.ly/ConsentU	nsent for them J16.		
	BLOCK CAPITALS USING A P			
Privacy Statement: In order to a managing vaccine(s), the HSE w accordance with the various data 2016/679 (General Data Protecti data will be lawful and fair. It will	nt form and return it in the end in the processing your child's person a protection legislation including the end in Regulation, GDPR), and the He only be processed for specific pures, to validate clients and provide here.	o record all of the neonal data. All data pone Data Protection alth Identifiers Act arposes including, to	ecessary data for mo processed by the HSE Acts 1988-2018, the 2014. The processing o manage the vaccina	nitoring and E will be in Regulation (EU) g of your child's
Notes/Comments:				
Personal Details				
PART 1 Compl	ete this part for all stud	dents (PLEAS	E USE BLOCK	CAPITALS)
Student's Forename:  Student's Surname (Family  Student's Personal Public S  (PPSN will be required to manage  Student's Date of Birth:	Name): Constitution of the	Student's Middle  Otherwise know		Female
D	LLLLLL DMMYYYY MMMMMMMMM			
Mother's surname at birth:	(This inform	mation may be requ	ired to manage your	child's immunisation)
Student's Address:				

FOR OFFICE USE ONLY	
Class:	Date of Birth:
Name: School Roll Number:	Client ID:
Eircode: County: Student's Address when they last had a vaccine: Parent/Legal Guardian Forename and Surname: Daytime Phone Number: Do you consent to receive texts about vaccine appointment Email:	nts? Yes No
Do you consent to receive emails about vaccine appointment of Student's ethnic or cultural background:  A. White (Irish, Irish traveller, Roma, Ukrainian, any other White background)  B. Black or Black Irish (African any other Black background)	
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	n description)
Student's Nationality:  Class:  School/College Name:  1. Has this student been in 1st year before?  2. Has this student previously received HPV vaccine?	Year:
3. Has this student had any serious illness in recent years  Please detail	
Are they currently taking medication?      Please detail	Yes No
<ol> <li>Has this student ever had a severe reaction to anythin medication or vaccine (including anaphylaxis)?</li> </ol> Please detail	Yes No
6. Do they have any illness or condition that increases the   Please detail	
People with the conditions listed below need 3 doses of H immune system. If you think you/your child have any of the Consultant if you require 3 doses of HPV vaccine due to have vaccination team when you attend your vaccination appointed. Haematopoietic stem cell or solid organ transplant recipies. HIV infection  Malignant haematological disorders affecting the bone lymphatic systems, e.g., leukaemia, lymphomas, blood Non-haematological malignant solid tumours  Non-haematological malignant solid tumours  Primary immunodeficiency  Within two weeks of commencing, on or within three to immunosuppressive therapy  I have been advised by my treating Specialist/Consultant thave 3 doses of HPV vaccine due to having a weak immunity you can ask your Specialist/ Consultant to visit www.immunity.	ese conditions please ask your Specialist/ aving a weak immune system, and tell the nament. pients  marrow or dyscrasias  six months of receiving significant hat I should he system.  Yes No

You can ask your Specialist/ Consultant to visit www.immunisation.ie for further information to help with this discussion.

Yes, I consent to the vaccination of the above named student with:  HPV	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 YE  Yes, I consent to the vaccination of the above named student with:  HPV	FOR OFFICE USE ONLY			
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 Yi  Yes, I consent to the vaccination of the above named student with:  HPV	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 YE  Yes, I consent to the vaccination of the above named student with:  HPV	Class:		Da	ate of Birth:
PART 2 Please tick the box for each vaccine you consent to and sign to say Yes, I consent to the vaccination of the above named student with:  HPV	PART 2 Please tick the box for each vaccine you consent to and sign to say YE.  Yes, I consent to the vaccination of the above named student with:  HPV	Name:	School Roll Number:		Client ID:
PART 2 Please tick the box for each vaccine you consent to and sign to say Yes, I consent to the vaccination of the above named student with:  HPV	PART 2 Please tick the box for each vaccine you consent to and sign to say YE.  Yes, I consent to the vaccination of the above named student with:  HPV	Choose Part	2 (YES) OR Part	3 (NO) for E/	ACH VACCINE
Yes, I consent to the vaccination of the above named student with:  HPV	Yes, I consent to the vaccination of the above named student with:  HPV				
HPV	HPV	PARI 2 PI	ease tick the box for each	vaccine you conse	ent to and sign to say YES
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 1 dose of HPV vaccine (complete this option if the person being vaccinated has a healthy immune system).  I understand that I am giving consent for the administration of 3 doses of HPV vaccine over 6 mc (complete this option if the Specialist/Consultant treating the person being vaccinated has advise 3 doses of HPV vaccine are needed due to immunocompromise/a weak immune system).  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:  Parent  Legal Guardian  Self  PART 3 Please tick the box for each vaccine you do not consent to and sign to say  No, I do not consent to the vaccination of the above named student with:  HPV  MenACWY  I have read and understand the accompanying vaccine information, including known side efferons in the properties of the part of the above named student (Students 16 years or older are legally entitled to consent on behalf of the above named student. (Students 16 years or older are legally entitled to consent on behalf of the above named student. (Students 16 years or older are legally entitled to consent for themselves)  Signature:  Date:	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 1 dose of HPV vaccine (complete this option if the person being vaccinated has a healthy immune system).  I understand that I am giving consent for the administration of 3 doses of HPV vaccine over 6 mon (complete this option if the Specialist/Consultant treating the person being vaccinated has advised 3 doses of HPV vaccine are needed due to immunocompromise/a weak immune system).  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:  Parent  Legal Guardian  Self  Phart 3 Please tick the box for each vaccine you do not consent to and sign to say in the properties of the vaccination of the above named student with:  HPV  Tdap  MenACWY  I have read and understand the accompanying vaccine information, including known side effect I confirm by signing this form that I am authorised to refuse consent on behalf of the above name student. (Students 16 years or older are legally entitled to consent for themselves)  Signature:  Date:  Dat	Yes, I consent to the	vaccination of the above n	amed student with:	
including known side effects.  I understand that I am giving consent for the administration of 1 dose of HPV vaccine (complete this option if the person being vaccinated has a healthy immune system).  I understand that I am giving consent for the administration of 3 doses of HPV vaccine (complete this option if the Specialist/Consultant treating the person being vaccinated has advised 3 doses of HPV vaccine are needed due to immunocompromise/a weak immune system).  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:  PART 3 Please tick the box for each vaccine you do not consent to and sign to say  No, I do not consent to the vaccination of the above named student with:  HPV	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 1 dose of HPV vaccine (complete this option if the person being vaccinated has a healthy immune system).  I understand that I am giving consent for the administration of 3 doses of HPV vaccine over 6 mon (complete this option if the Specialist/Consultant treating the person being vaccinated has advised 3 doses of HPV vaccine are needed due to immunocompromise/a weak immune system).  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:  Greater Date:  Parent  Legal Guardian  Self  MenACWY  I have read and understand the accompanying vaccine information, including known side effect  I confirm by signing this form that I am authorised to refuse consent on behalf of the above name student. (Students 16 years or older are legally entitled to consent for themselves)  Signature:  Date:  Date:	HPV Tda	p MenACWY		<b>20Y</b>
I understand that I am giving consent for the administration of 1 dose of HPV vaccine (complete this option if the person being vaccinated has a healthy immune system).  I understand that I am giving consent for the administration of 3 doses of HPV vaccine over 6 mc (complete this option if the Specialist/Consultant treating the person being vaccinated has advise 3 doses of HPV vaccine are needed due to immunocompromise/a weak immune system).  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:  General Date:  Consent Date:  PART 3 Please tick the box for each vaccine you do not consent to and sign to say  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 of the confirm by signing this form that I am authorised to refuse consent on behalf of the above named students. (Students 16 years or older are legally entitled to consent for themselves)  Signature:  Dead of HPV vaccine over 6 mc (complete the subcine of the above named student with the accompanying vaccine information, including known side effects of the subcine of the above named student. (Students 16 years or older are legally entitled to consent for themselves)	I understand that I am giving consent for the administration of 1 dose of HPV vaccine (complete this option if the person being vaccinated has a healthy immune system).  I understand that I am giving consent for the administration of 3 doses of HPV vaccine over 6 mon (complete this option if the Specialist/Consultant treating the person being vaccinated has advised 3 doses of HPV vaccine are needed due to immunocompromise/a weak immune system).  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:  Consent Date:  Parent  Legal Guardian  Self  Phart 3 Please tick the box for each vaccine you do not consent to and sign to say I make the properties of the above named student with:  Phy Menacy  I have read and understand the accompanying vaccine information, including known side effect  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:  Date:  Date:  Date:  Parent  Legal Guardian  Self  Parent  Legal Guardian  Self  Parent  Legal Guardian  Self			vaccine information,	
(complete this option if the person being vaccinated has a healthy immune system).  I understand that I am giving consent for the administration of 3 doses of HPV vaccine over 6 mc (complete this option if the Specialist/Consultant treating the person being vaccinated has advise 3 doses of HPV vaccine are needed due to immunocompromise/a weak immune system).  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:  Consent Date:  Parent  Legal Guardian  Self  Parent  Legal Guardian  Self  MenACWY  I have read and understand the accompanying vaccine information, including known side effection of the above named students. (Students 16 years or older are legally entitled to consent for themselves)  Signature:  D D M M Y STANDARD PROBLEM SELECTION OF THE ADDRESS OF	(complete this option if the person being vaccinated has a healthy immune system).  I understand that I am giving consent for the administration of 3 doses of HPV vaccine over 6 mon (complete this option if the Specialist/Consultant treating the person being vaccinated has advised 3 doses of HPV vaccine are needed due to immunocompromise/a weak immune system).  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:  Consent Date:  Consent Date:  Parent  Legal Guardian  Self  Parent  Legal Guardian  Self  No, I do not consent to the vaccination of the above named student with:  HPV  Tdap  MenACWY  MenACWY  I have read and understand the accompanying vaccine information, including known side effect  I confirm by signing this form that I am authorised to refuse consent on behalf of the above nam student. (Students 16 years or older are legally entitled to consent for themselves)  Signature:  Date:  Dat			0.0	
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Signature: Consent Date:	Signature: Consent Date:			•	• •
Name (Please print):    Parent	Signature: D D M M Y Y  Name (Please print): Legal Guardian Self  PART 3 Please tick the box for each vaccine you do not consent to and sign to say 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 effect  I confirm by signing this form that I am authorised to refuse consent on behalf of the above nam student. (Students 16 years or older are legally entitled to consent for themselves)  Signature: Date:	named student. (S	Students 16 years or older are	e legally entitled to cor	nsent for themselves)
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PART 3 Please tick the box for each vaccine you do not consent to and sign to say  No, I do not consent to the vaccination of the above named student with:  HPV	PART 3 Please tick the box for each vaccine you do not consent to and sign to say No, I do not consent to the vaccination of the above named student with:  HPV	Signature:			D D M M Y Y Y
PART 3 Please tick the box for each vaccine you do not consent to and sign to say  No, I do not consent to the vaccination of the above named student with:  HPV	PART 3 Please tick the box for each vaccine you do not consent to and sign to say No, I do not consent to the vaccination of the above named student with:  HPV	Name (Please print):			
No, I do not consent to the vaccination of the above named student with:  HPV	No, I do not consent to the vaccination of the above named student with:  HPV	(Please tick): Parent	Legal Guardian	Self	
No, I do not consent to the vaccination of the above named student with:  HPV	No, I do not consent to the vaccination of the above named student with:  HPV				
No, I do not consent to the vaccination of the above named student with:  HPV	No, I do not consent to the vaccination of the above named student with:  HPV	DART 3 No.			
<ul> <li>HPV  MenACWY   <ul> <li>I have read and understand the accompanying vaccine information, including known side effects</li> <li>I confirm by signing this form that I am authorised to refuse consent on behalf of the above nare student. (Students 16 years or older are legally entitled to consent for themselves)</li> </ul> </li> <li>Signature: Date:</li></ul>	HPV	TAIL 3 Pies	ase tick the dox for each va	accine you do not co	nsent to and sign to say <b>N</b>
<ul> <li>I have read and understand the accompanying vaccine information, including known side effects.</li> <li>I confirm by signing this form that I am authorised to refuse consent on behalf of the above nare student. (Students 16 years or older are legally entitled to consent for themselves)</li> <li>Signature:</li></ul>	<ul> <li>I have read and understand the accompanying vaccine information, including known side effect</li> <li>I confirm by signing this form that I am authorised to refuse consent on behalf of the above nam student. (Students 16 years or older are legally entitled to consent for themselves)</li> <li>Signature:</li></ul>	No, I do not consent	to the vaccination of the al	oove named student	with:
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student. (Students 16 years or older are legally entitled to consent for themselves)  Signature:  Date:  D D M M Y	student. (Students 16 years or older are legally entitled to consent for themselves)  Signature:  Date:  Discription:  Name (Please print):  (Please tick):  Parent  Legal Guardian  Self	<ul> <li>I have read and u</li> </ul>	nderstand the accompanying	vaccine information,	including known side effects.
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Signature: D M M Y Y	Signature: D D M M Y Y  Name (Please print): Legal Guardian Self	Signature:			Date:
	Name (Please print):  (Please tick): Parent Legal Guardian Self				D D M M Y Y Y
Ivaine (riease pility).					
(Please tick): Parent Legal Guardian Self	Reason for Refusal:	(Please tick): Parent	Legal Guardian	Self	

FOR OFF	FICE USE ONLY	_					immunisation
Name:		School Roll N	lumber:		Client I	D:	
VISIT 1 HPV (Dose one) + Tdap + MenACWY							
HPV Dose	Date Given	Batch Number		d by signature ICRN/PIN	Vaccinator's sig		Injection Site (Circle as appropriat
1	D D M M Y Y Y Y						Right Left Deltoid Delto
Time V	/accinated:	AM/PM		Vaccina	tion Location:	School	Clinic
Clinic I	Name:						
Tdap Dose	Date Given	Batch Number		d by signature ICRN/PIN	Vaccinator's sig and PIN/MC		Injection Site (Circle as appropriat
	D D M M Y Y Y Y						Right Left Deltoid Delto
Time V	/accinated:	AM/PM		Vaccina	tion Location:	School	Clinic
Clinic I	Name:			'			
Men- ACWY	Date Given	Batch Number		d by signature ICRN/PIN	Vaccinator's sig		Injection Site (Circle as appropriat
Dose	D D M M Y Y Y Y						Right Left Deltoid Delto
Time V	/accinated:	AM/PM	I	Vaccina	tion Location:	School	Clinic
Clinic I	Name:						
Compl	eted by:			N/PIN:			
If vacci	ine not administered	nlease state wh	(if appl	<sup>licable)</sup> DNA or Ab	sent		D MMYYYY ed on the Day
	e Contraindicated	Deferred	Othe		John Line		
	<b>F 2 HPV</b> (Dose tv		_				
	•	•		d by signature	Vaccinator's sig	nature	Injection Site
HPV Dose	Date Given	Batch Number		ICRN/PIN	and PIN/MC		(Circle as appropriat
2	D D M M Y Y Y Y						Right Left Deltoid Delto
Time V	/accinated:	AM/PM		Vaccina	tion Location:	School	Clinic
Clinic I	Name:						
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If vacci	ine not administered	please state wh	(if appl NY?	DNA or Ab	sent	_	on the Day
	e Contraindicated	Deferred	Othe				
	「3 HPV (Dose th						
				d by signature	Vaccinator's sig	nature	Injection Site
HPV Dose	Date Given	Batch Number		ICRN/PIN	and PIN/MC		(Circle as appropriat
3	D D M M Y Y Y Y						Right Left Deltoid Delto
Time V	/accinated:	AM/PM		Vaccina	tion Location:	School	Clinic
Clinic I	Name:						
-	eted by:		(if app	•		_	D M M Y Y Y
If vacci	ine not administered	please state wh		DNA or Ab	sent	Refuse	ed on the Day
Vaccine	e Contraindicated	Deferred	Othe	er			