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)
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: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] 

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
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: ____________

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: ____________

Name (Please print): ___________________________ (Please tick): Parent □ Legal Guardian □ Self □

Reason for Refusal: ____________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
**FOR OFFICE USE ONLY**

### VISIT 1

**HPV Dose**

<table>
<thead>
<tr>
<th>Date Given</th>
<th>Batch Number</th>
<th>Prescribed by signature and MCRN/PIN</th>
<th>Vaccinator’s signature and PIN/MCRN</th>
<th>Injection Site (Circle as appropriate)</th>
<th>Right Deltoid</th>
<th>Left Deltoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Tdap Dose</th>
<th>Date Given</th>
<th>Batch Number</th>
<th>Prescribed by signature and MCRN/PIN</th>
<th>Vaccinator’s signature and PIN/MCRN</th>
<th>Injection Site (Circle as appropriate)</th>
<th>Right Deltoid</th>
<th>Left Deltoid</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Completed by:** ______________________  
**MCRN/PIN:** ______________________  

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

Vaccine Contraindicated ☐ Deferred ☐ Other ______________________

### VISIT 2

**HPV Dose**

<table>
<thead>
<tr>
<th>Date Given</th>
<th>Batch Number</th>
<th>Prescribed by signature and MCRN/PIN</th>
<th>Vaccinator’s signature and PIN/MCRN</th>
<th>Injection Site (Circle as appropriate)</th>
<th>Right Deltoid</th>
<th>Left Deltoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MenACWY Dose</th>
<th>Date Given</th>
<th>Batch Number</th>
<th>Prescribed by signature and MCRN/PIN</th>
<th>Vaccinator’s signature and PIN/MCRN</th>
<th>Injection Site (Circle as appropriate)</th>
<th>Right Deltoid</th>
<th>Left Deltoid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Completed by:** ______________________  
**MCRN/PIN:** ______________________  

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

Vaccine Contraindicated ☐ Deferred ☐ Other ______________________