## Class: School Roll Number: Client ID: Name: Date of Birth:

## Vaccination Consent Form for children starting 1st Year of secondary school in September 2020 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

FOR OFFICE USE ONLY

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					
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 Surname (Family N  Student's Personal Public Ser (PPSN will be required to manage ye	rvices Number (PPSN):	Student's Mid Otherwise kno			
Student's Date of Birth:			Gender: Male	Female	
Mother's Maiden Name:		rmation may be re	equired to manage your	child's immunisation)	
Student's Address:	ame and Surname:  ame and Surname:  cts about vaccine appoint  st year before?  Ity received HPV vaccine	9?		Yes No Yes Yes No Yes N	
Please detail	medication?			Yes No	
Has this student ever had medication or vaccine (income detail)  Please detail.	cluding anaphylaxis)?		g	Yes No	
6. Do they have any illness of Please detail			bleeding?	Yes No	

FOR OFFICE USE	ONLY				
Class:	School Roll Number:	Client ID:			
Name:		Date of Birth:			
Choose Part 2 (Y	<b>ES</b> ) OR Part 3 (NO)	for EACH VACCINE			
PART 2 Please ti	ick the box for each vaccine yo	u consent to and sign to say <b>YES</b>			
Yes, I consent to the vaccin	nation of the above named stude	nt with:			
HPV Tdap	MenACWY				
I have read and understar including known side effe	nd the accompanying vaccine info	rmation,			
I understand that HPV vaccine is not recommended during pregnancy.					
<ul> <li>I understand that I am giv of HPV over 6 to 12 mont</li> </ul>	ving consent for the administration ths.	of 2 doses			
, , ,	form that I am authorised to give co s 16 years or older are legally entit				
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	k the box for each vaccine you d	o not consent to and sign to say <b>NO</b>			
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.					
, ,	form that I am authorised to refuse ars or older are legally entitled to co	consent on behalf of the above named onsent 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 Batch Prescribed by signature Date Vaccinator's signature Injection Site Dose Given Number and MCRN/PIN and PIN/MCRN (Circle as appropriate) Right Left Deltoid D D M M Y Y Y Deltoid AM/PM Clinic **Time Vaccinated:** Vaccination Location: School Clinic Name: **Tdap** Date Batch Prescribed by signature Vaccinator's signature Injection Site Dose Given Number and MCRN/PIN and PIN/MCRN (Circle as appropriate) Right Left Deltoid Deltoid D D M M Y Y Y AM/PM **Time Vaccinated:** Vaccination Location: School Clinic Clinic Name: MCRN/PIN: Completed by: (if applicable) D D м м If vaccine not administered please state why? DNA or Absent Refused on the Day Other Vaccine Contraindicated Deferred 2 HPV (Dose two) + MenACWY **HPV** Prescribed by signature Date Batch Vaccinator's signature Injection Site Number and MCRN/PIN and PIN/MCRN (Circle as appropriate) Dose Given Right Left Deltoid Deltoid Time Vaccinated: AM/PM Vaccination Location: School Clinic Clinic Name: Men-Prescribed by signature Date Batch Vaccinator's signature Injection Site **ACWY** Given Number and MCRN/PIN and PIN/MCRN (Circle as appropriate) Dose Left Right Deltoid Deltoid ММ **Time Vaccinated:** AM/PM Vaccination Location: School Clinic Clinic Name: Completed by: MCRN/PIN: D D M M Y Y Y Y (if applicable) DNA or Absent If vaccine not administered please state why? Refused on the Day Vaccine Contraindicated Deferred Other

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