

FOR OFFICE 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 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

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**

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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	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Right Deltoid	Left Deltoid
	D D M M Y Y Y Y					
Time Vaccinated: AM/PM			Vaccination Location: School <input type="checkbox"/> Clinic <input type="checkbox"/>			
Clinic Name: <input type="text"/>						

Tdap Dose	Date Given	Batch Number	Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN	Injection Site (Circle as appropriate)	
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Right Deltoid	Left Deltoid
	D D M M Y Y Y Y					
Time Vaccinated: AM/PM			Vaccination Location: School <input type="checkbox"/> Clinic <input type="checkbox"/>			
Clinic Name: <input type="text"/>						

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 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	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Right Deltoid	Left Deltoid
	D D M M Y Y Y Y					
Time Vaccinated: AM/PM			Vaccination Location: School <input type="checkbox"/> Clinic <input type="checkbox"/>			
Clinic Name: <input type="text"/>						

Men-ACWY Dose	Date Given	Batch Number	Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN	Injection Site (Circle as appropriate)	
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Right Deltoid	Left Deltoid
	D D M M Y Y Y Y					
Time Vaccinated: AM/PM			Vaccination Location: School <input type="checkbox"/> Clinic <input type="checkbox"/>			
Clinic Name: <input type="text"/>						

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