

# Queensland School Immunisation Program

## Vaccination Consent card – Year 10



Please return this card to your child's school with all information required – print clearly using a black or blue pen

### Student details

School	Class
Surname	
Given name/s	
Date of birth	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
Medicare number <i>(must be completed)</i>	Ref no. beside your child's name on the Medicare card
Is your child	
<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Torres Strait Islander (TSI)
<input type="checkbox"/> Not Aboriginal or TSI	<input type="checkbox"/> Aboriginal & TSI
Language spoken at home <input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>please specify</i>	
Address	
Postcode	

### Parent / legal guardian / authorised person details

Name of parent/ legal guardian/ authorised person
Mobile
Other phone number
Email
Relationship to student <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Authorised person (attach <i>Authority to care</i> )
Is your address the same as your child <input type="checkbox"/> Yes <input type="checkbox"/> No If NO please record your address
Address
Postcode

### Pre-vaccination checklist *(tick all that apply)*

- My child
- has previously had a reaction to a vaccine  has recently received a vaccine/s
- faints when given an injection  is pregnant
- has severe allergies

If you have ticked any box above, please give details: \_\_\_\_\_

Note: you may be contacted for further information.

### Consent statement

*I have read and understood the information given to me about meningococcal vaccination, including risks and side effects. I have been given the opportunity to discuss the risks and benefits of vaccination with my doctor or by telephoning 13 HEALTH (13 43 25 84). I am authorised as the parent, legal guardian or authorised person of this child to give consent for the child to be vaccinated. I understand that consent can be withdrawn at any time before vaccination by making a written request to the school immunisation provider. I understand vaccination details will be recorded on the Australian Immunisation Register (AIR) and used by Queensland Health and the school immunisation provider for recall, reminders, clinic follow up; or disease prevention, control and monitoring; or as otherwise authorised by or required by law.*

Please sign and date EACH vaccine you wish your child to receive:

#### Meningococcal ACWY vaccine

On the basis of the above consent statement,

**YES** I hereby give consent for my child to receive a single dose of the meningococcal ACWY vaccine.

#### Parent/legal guardian/authorised person

Signature \_\_\_\_\_

Date / / 20

Office use only: consent checked

#### Meningococcal B vaccine

On the basis of the above consent statement,

**YES** I hereby give consent for my child to receive 2 doses of the meningococcal B vaccine.

Dose 1  Dose 2

#### Parent/legal guardian/authorised person

Signature \_\_\_\_\_

Date / / 20

Office use only: consent checked Dose 1  Dose 2

If you have completed the “Yes to consent” section you do not need to complete this section.  
Proceed to the Record of vaccination over page.



## Queensland School Immunisation Program

### No to vaccination

If you wish to decline the meningococcal vaccination, please complete the information below, sign and return to your child's school.

Student's Name \_\_\_\_\_

Date of Birth / / 20  Female  Male  Other

School \_\_\_\_\_

#### Meningococcal ACWY vaccine

**NO**, I do not give consent for my child to receive a single dose of the meningococcal ACWY vaccine.

I have planned my child's vaccination with my family doctor  Yes  No

Other \_\_\_\_\_

Signature \_\_\_\_\_ Date / / 20

Parent/legal guardian/authorised person (attach *Authority to care*)

#### Meningococcal B vaccine

**NO**, I do not give consent for my child to receive 2 doses of meningococcal B vaccine.

I have planned my child's vaccination with my family doctor  Yes  No

Other \_\_\_\_\_

Signature \_\_\_\_\_ Date / / 20

Parent/legal guardian/authorised person (attach *Authority to Care*)

DO NOT DETACH

Office use only:

PID no.

**Record of vaccination**

**Name of Student**

Surname

Given Names

**OFFICE USE ONLY**

Vaccine	Date of vaccination (dd/mm/yyyy)	Time of vaccination (24hr)	Arm	Batch number	Vaccinator's signature/stamp
<b>Meningococcal ACWY</b>	/ / 20	:	<input type="checkbox"/> L <input type="checkbox"/> R		
Pre-vaccination assessment <input type="checkbox"/>	<input type="checkbox"/> Absent <input type="checkbox"/> Refused	<input type="checkbox"/> Unwell <input type="checkbox"/> Consent withdrawn	<input type="checkbox"/> AEFI <input type="checkbox"/> Other		
<b>Meningococcal B Dose 1</b>	/ / 20	:	<input type="checkbox"/> L <input type="checkbox"/> R		
Pre-vaccination assessment <input type="checkbox"/>	<input type="checkbox"/> Absent <input type="checkbox"/> Refused	<input type="checkbox"/> Unwell <input type="checkbox"/> Consent withdrawn	<input type="checkbox"/> AEFI <input type="checkbox"/> Other		
<b>Meningococcal B Dose 2</b>	/ / 20	:	<input type="checkbox"/> L <input type="checkbox"/> R		
Pre-vaccination assessment <input type="checkbox"/>	<input type="checkbox"/> Absent <input type="checkbox"/> Refused	<input type="checkbox"/> Unwell <input type="checkbox"/> Consent withdrawn	<input type="checkbox"/> AEFI <input type="checkbox"/> Other		

Date	Vaccinator notes