2023 YEAR 7 SA School Immunisation Program Consent Card

Government of South Australia
SA Health

1. Please complete this form even if not consenting, and select "do not consent' over the page.
2. Parent/Legal Guardian to complete ALL details fully using blue or black pen in BLOCK LETTERS
3. Complete BOTH sides of card
4. RETURN card to the school

Year 7 or 8 student details

Name of School .....

Class (Home Room, Colour, etc) .....

Legal Family Name .....

Legal Given Name(s) .....

Date of Birth ...../...../..... Age.....

Male ☐ Female ☐ Another term ☐ Prefer not to say ☐

Medicare number ☐☐☐☐ ☐☐☐☐☐ **Reference number next to student's name** ☐☐

Main language spoken at home .....

Postal address .....

Suburb ..... Postcode .....

Aboriginal and Torres Strait Islander ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither ☐

Parent/Legal Guardian details

Mr / Mrs / Miss / Ms (please circle)

Family Name .....

Given Name(s) .....

Relationship to Student Parent ☐ Legal Guardian ☐

Contact Phone (Home/Work) ..... (Mobile) .....

Email .....

Email and phone numbers may be used to clarify information if required.

Alternative emergency contact (school hours only)

Name .....

Relationship to child ..... Contact Phone (Home/Work) .....

(Mobile) .....

Year 7 and 8 pre-vaccination checklist

Please tick the appropriate box(es) if the student:

- ☐ has previously had a reaction to a vaccine
- ☐ has ever fainted when given an injection
- ☐ is taking any medication
- ☐ has any allergies/Allergy Plan
- ☐ is pregnant
- ☐ has a bleeding disorder
- ☐ has lowered immunity (eg leukaemia, cancer, HIV/AIDS, radiotherapy, chemotherapy or oral steroids)

Please describe .....

.....

Before vaccination, the nurse will ask the student about the above information and **must be informed of any changes** as it may be several weeks or more between completing this card and receiving the vaccine(s).

Parent/Legal Guardians please read the following before completing the consent section on the other side of this card.

- I have read and understood the information on the Year 7 and 8 Parent/Legal Guardian Information Sheet including the risk of vaccination and the risk of diphtheria, tetanus, whooping cough and human papillomavirus (HPV).
- I understand that I can contact my School Immunisation Program provider to discuss these risks and benefits.
- I understand that I can withdraw consent at any time before vaccination takes place by contacting the School Immunisation Program provider.
- I understand the information provided on the Consent Card, and information related to vaccines administered will be stored electronically and/or in hard copy as a medical record. I consent to disclosure of this information to staff involved in the provision of an immunisation service for SA Health and local government councils and their immunisation providers. I understand that immunisation records will be recorded on the Australian Immunisation Register where it will be stored on my child's Medicare account.

Please complete the required information over the page →

OFFICIAL: Sensitive//Medical in confidence

1. Parent/Legal Guardians to complete **BOTH** sides of card 2. Tick the relevant boxes below, **SIGN** and **RETUR**

YEAR 7

Student name:.....

Human papillomavirus (HPV)

YES

☐ **I consent** for this student to receive **2 doses** of the HPV vaccine (**Gardasil®9**).

SIGN HERE

Parent/Legal Guardian signature:

_____ Date: ____/____/_____

Comments

_____

_____

_____

NO

☐ **I do not consent** for this student to receive the **Gardasil®9** vaccine.

☐ This student has already received the HPV vaccine on:

1) ____/____/_____ 2) ____/____/_____

SIGN HERE

Parent/Legal Guardian signature:

_____ Date: ____/____/_____

Diphtheria, tetanus, whooping cough booster

YES

☐ **I consent** for this student to receive the **adolescent booster** dose of the diphtheria, tetanus and whooping cough vaccine (**Boostrix®**). This is in addition to all other childhood doses.

SIGN HERE

Parent/Legal Guardian signature:

_____ Date: ____/____/_____

Comments

_____

_____

_____

NO

☐ **I do not consent** for this student to receive the **Boostrix®** vaccine.

☐ This student has already received the **adolescent booster** dose of diphtheria, tetanus and whooping cough vaccine on: ____/____/_____

SIGN HERE

Parent/Legal Guardian signature:

_____ Date: ____/____/_____

Office Use Only (Parent/Legal Guardians/Student **DO NOT COMPLETE**)

Gardasil®9 Dose 1

☐ Student ID and consent verified

Date: ...../...../.....

Time: ..... Batch No:.....

☐ L arm

☐ R arm Given by:.....

Gardasil®9 Dose 2

☐ Student ID and consent verified

Date: ...../...../.....

Time: ..... Batch No:.....

☐ L arm

☐ R arm Given by:.....

Boostrix®

☐ Student ID and consent verified

Date: ...../...../.....

Time: ..... Batch No:.....

☐ L arm

☐ R arm Given by:.....