FOR OFFICE USE ONLY

Class: | Date of Birth:

Name: | School Roll Number: | Client ID:

Vaccination Consent Form 2023/2024

for children starting Junior Infants **Measles, Mumps, Rubella** (MMR) and **Diphtheria, Polio, Tetanus, Whooping Cough (Pertussis)** (4 in 1)

If you wish to give consent please fill in Parts 1 & 2. If you do not wish to give consent please fill in parts 1 & 3. (Parts 2 & 3 are overleaf). Please note only a parent or legal guardian can consent or refuse consent for students. Please return form to your school as soon as possible in the envelope provided. Read more about consent on the HSE website https://bit.ly/ConsentU16.

Privacy Statement: In order to administer vaccine(s) safely, and to record all of the necessary data for monitoring and managing vaccine(s), the HSE will be processing your child's personal data. All data processed by the HSE will be in accordance with the various data protection legislation including the Data Protection Acts 1988-2018, the Regulation (EU) 2016/679 (General Data Protection Regulation, GDPR), and the Health Identifiers Act 2014. The processing of your child's data will be lawful and fair. It will only be processed for specific purposes including, to manage the vaccinations, to report and monitor vaccination programmes, to validate clients and provide health care. Data sharing between HSE departments may also occur.

PART 1 Complete this part for all children (PLEASE USE BLOCK CAPITALS)

Child's Forename: Child's Middle Name:

Child's Surname (Family Name):

Otherwise known as:

Child's Personal Public Services Number (PPSN):

(PPSN will be required to manage your immunisation record only)

Email:

Do you consent to receive emails about vaccine appointments? Yes ☐ No ☐

Child's Date of Birth: D D M M Y Y Y Y Child's Gender: Male ☐ Female ☐

Mother's surname at birth:

(This information may be required to manage your child's immunisation)

Child's Address:

Eircode: County:

Child's Address when they last had a vaccine:

Parent/Legal Guardian Forename and Surname:

Daytime Phone Number:

Mobile Phone Number:

Do you consent to receive texts about vaccine appointments? Yes ☐ No ☐

Please turn over →

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Class: ____ Date of Birth: ____

Name: ____ School Roll Number: ____ Client ID: ____

Child's ethnic or cultural background:

A. White *(Irish, Irish traveller, Roma, Ukrainian, any other White background)* ☐

B. Black or Black Irish *(African, any other Black background)* ☐

C. Asian or Asian Irish *(Chinese, any other Asian background)* ☐

D. other, including mixed background *(Arabic, any other write in description)* ☐

Description ____

Child's Nationality: ____

School: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Year: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Class Name OR Number OR Letter: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Is this your child's first year in Junior Infants? Yes ☐ No ☐

Has this child received their routine vaccines due at 2, 4 and 6 months? Yes ☐ No ☐ Do Not Know ☐

Has this child received their first MMR vaccine due at 12 months? Yes ☐ No ☐ Do Not Know ☐

Has this child had any vaccines in the past 6 months? Yes ☐ No ☐

Please detail ____

Has your child already had a second MMR vaccine for travel/outbreak? Yes ☐ No ☐

Please detail ____

Has this child had any serious illness? Yes ☐ No ☐

Please detail ____

Is this child currently taking medication? Yes ☐ No ☐

Please detail ____

Has this child ever had a severe reaction to **anything** including medication or vaccines? Yes ☐ No ☐
(including anaphylaxis)

Please detail ____

Does this child have any illness or condition that increases their risk of bleeding? Yes ☐ No ☐

Please detail ____

PART 2 Please sign these boxes to say **Yes**

Sign this box if you do wish to give consent for MMR

Yes, I consent to have the above named child vaccinated to protect against **Measles, Mumps and Rubella (MMR)**. I have read and understand the accompanying vaccine information, including known side effects. I confirm by signing this form that I am authorised to give consent on behalf of the above named child.

Signature: ____
(Parent/Legal Guardian)

My Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date: ☐☐ ☐☐ ☐☐☐☐ (D D M M Y Y Y Y)
Please print

Signature: ____
(Parent/Legal Guardian)

My Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date: ☐☐ ☐☐ ☐☐☐☐ (D D M M Y Y Y Y)
Please print

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Sign this box if you do wish to give consent for 4 in 1

Yes, I consent to have the above named child vaccinated to protect against **Diphtheria, Polio Tetanus and Whooping Cough (4 in 1)**. I have read and understand the accompanying vaccine information, including known side effects. I confirm by signing this form that I am authorised to give consent on behalf of the above named child.

Signature: _____

(Parent/Legal Guardian)

My Name: _____ Date: D D M M Y Y Y Y

Please print

Signature: _____

(Parent/Legal Guardian)

My Name: _____ Date: D D M M Y Y Y Y

Please print

PART 3 Please sign these boxes to say **No**

Sign this box if you do not wish to give consent for MMR

No, I do not consent to have the above named child vaccinated to protect against **Measles, Mumps and Rubella (MMR)**. I have read and understand the accompanying vaccine information, including risks of not vaccinating. I confirm by signing this form that I am authorised to refuse consent on behalf of the above named child.

Signature: _____

(Parent/Legal Guardian)

My Name: _____ Date: D D M M Y Y Y Y

Please print

Signature: _____

(Parent/Legal Guardian)

My Name: _____ Date: D D M M Y Y Y Y

Please print

Reason for refusal: _____

Sign this box if you do not wish to give consent for 4 in 1

No, I do not consent to have the above named child vaccinated to protect against **Diphtheria, Polio, Tetanus and Whooping Cough (4 in 1)**. I have read and understand the accompanying vaccine information, including risks of not vaccinating. I confirm by signing this form that I am authorised to refuse consent on behalf of the above named child.

Signature: _____

(Parent/Legal Guardian)

My Name: _____ Date: D D M M Y Y Y Y

Please print

Signature: _____

(Parent/Legal Guardian)

My Name: _____ Date: D D M M Y Y Y Y

Please print

Reason for refusal: _____

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Class: | Date of Birth:

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For Office Use Only Administration Details:

MMR	Date Given	Batch Number	Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN	Injection Site (Circle as appropriate)	
	D D M M Y Y Y Y				Right Deltoid	Left Deltoid
Time Vaccinated:	**AM/PM**		Vaccination Location: School ☐		Clinic ☐	
Clinic Name:						

4 in 1	Date Given	Batch Number	Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN	Injection Site (Circle as appropriate)	
	D D M M Y Y Y Y				Right Deltoid	Left Deltoid
Time Vaccinated:	**AM/PM**		Vaccination Location: School ☐		Clinic ☐	
Clinic Name:						

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

Vaccine Contraindicated ☐ Deferred ☐ Other

Completed by: _____ **MCRN/PIN:** _____ D D M M Y Y Y Y

(if applicable)

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Notes/Comments:

Junior Infants