FOR OFFICE USE ONLY

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

Vaccination Consent Form 2023/2024

for children starting 1st Year of secondary school **HPV**, **Tdap** and **MenACWY** vaccines

This consent form needs to be completed

- 1 dose of **HPV vaccine** (for those with a healthy immune system) OR 3 doses of **HPV vaccine** (for those with a weak immune system)
- 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.
3 vaccines will be given at a school visit.

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. Read more about consent on the HSE website https://bit.ly/ConsentU16.

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: 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.

Notes/Comments:

Personal Details

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

Student's Forename:

Student's Middle Name:

Student's Surname (Family Name):

Otherwise known as:

Student's Personal Public Services Number (PPSN):

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

Student's Date of Birth: D D M M Y Y Y Y

Gender: Male ☐ Female ☐

Mother's surname at birth:

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

Student's Address:

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Eircode: County:

Student'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 ☐

Email:

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

Student'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 __________

Student's Nationality: __________

Class: Year:

School/College Name:

1. Has this student been in 1st year before? Yes ☐ No ☐
2. Has this student previously received HPV vaccine? Yes ☐ No ☐
3. Has this student had any serious illness in recent years? Yes ☐ No ☐

   Please detail __________
4. Are they currently taking medication? Yes ☐ No ☐

   Please detail __________
5. Has this student ever had a severe reaction to **anything** including medication or vaccine (including anaphylaxis)? Yes ☐ No ☐

   Please detail __________
6. Do they have any illness or condition that increases their risk of bleeding? Yes ☐ No ☐

   Please detail __________

People with the conditions listed below need 3 doses of HPV vaccine because they have a weak immune system. If you think you/your child have any of these conditions please ask your Specialist/ Consultant if you require 3 doses of HPV vaccine due to having a weak immune system, and tell the vaccination team when you attend your vaccination appointment.

- Haematopoietic stem cell or solid organ transplant recipients
- HIV infection
- Malignant haematological disorders affecting the bone marrow or
- lymphatic systems, e.g., leukaemia, lymphomas, blood dyscrasias
- Non-haematological malignant solid tumours
- Primary immunodeficiency
- Within two weeks of commencing, on or within three to six months of receiving significant immunosuppressive therapy

I have been advised by my treating Specialist/Consultant that I should have 3 doses of HPV vaccine due to having a weak immune system. Yes ☐ No ☐

You can ask your Specialist/ Consultant to visit www.immunisation.ie for further information to help with this discussion.

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Choose Part 2 (**YES**) OR Part 3 (NO) for EACH VACCINE

PART 2 Please tick the box for each vaccine you consent to and sign to say **YES**

Yes, I 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.
- I understand that HPV vaccine is not recommended during pregnancy.
- I understand that I am giving consent for the administration of 1 dose of HPV vaccine (complete this option if the person being vaccinated has a healthy immune system). ☐
- I understand that I am giving consent for the administration of 3 doses of HPV vaccine over 6 months (complete this option if the Specialist/Consultant treating the person being vaccinated has advised 3 doses of HPV vaccine are needed due to immunocompromise/a weak immune system). ☐
- I confirm by signing this form that I am authorised to give consent on behalf of the above named student. (Students 16 years or older are legally entitled to consent for themselves)

Signature: ______ Consent Date: D D M M Y Y Y Y

Signature: ______

Name *(Please print)*: ______

(Please tick): Parent ☐ Legal Guardian ☐ Self ☐

PART 3 Please tick the box for each vaccine you do not consent to and sign to say **NO**

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.
- I confirm by signing this form that I am authorised to refuse consent on behalf of the above named student. (Students 16 years or older are legally entitled to consent for themselves)

Signature: ______ Date: D D M M Y Y Y Y

Signature: ______

Name *(Please print)*: ______

(Please tick): Parent ☐ Legal Guardian ☐ Self ☐

Reason for Refusal: ______

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Name: **School Roll Number:**   **Client ID:**

VISIT 1 HPV (Dose one) + Tdap + MenACWY

HPV Dose 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:						

Tdap Dose	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:						

Men-ACWY Dose	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:						

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) if immunocompromised

HPV Dose 2	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:						

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 3 HPV (Dose three) if immunocompromised

HPV Dose 3	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:						

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 ______________