Immunisation Consent Form 2024/2025
for students starting 1st Year of secondary school **HPV, Tdap** and **MenACWY** vaccines

First Year

This immunisation 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.

COMPLETE THE FORM IN BLOCK CAPITALS USING A PEN.

Please complete the details in Parts 1-4 and return it in the envelope provided before the vaccinations begin.

Part 1: Student Personal Details

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

Student Forename: Student Middle Name:

Student Surname (Family Name):

Otherwise known as:

Personal Public Services Number (PPSN):

Date of Birth: D D M M Y Y Y Y

Sex at birth: Male Female

Mother's surname at birth:

Address:

Eircode:

County:

Student's Address when they last had a vaccine:

Student's ethnic or cultural background:

A. White

A.1 Irish
A.2 Irish Traveller
A.3 Roma
A.4 Any other White background

B. Black or Black Irish

B.1 African
B.2 Any other Black background

C. Asian or Asian Irish

C.1 Chinese
C.2 Indian/Pakistani/Bangladeshi
C.3 Any other Asian background

D. Other, including mixed background

D.1 Arab
D.2 Mixed, write in description
Description

D.3 Other, write in description
Description

E. Prefer not to say

Student's Country of Birth:

Class:

Year:

School/College Name:

FOR OFFICE USE ONLY

Name: Date of Birth:

Class: School Roll Number: PID:

Part 2: Parent/Guardian Personal Details

Parent/Legal Guardian Forename and Surname:

Daytime Phone Number:

Mobile Phone Number:

Email:

Has this student been in 1st year before? Yes ☐ No ☐

If you tick yes to any of the Student Medical Details in Part 3 the Schools Immunisation Team may need to contact you to discuss further. Please note we will send you an appointment confirmation and/or reminders by SMS and/or email.

PART 3: Student Medical Details

1. Has this student previously received HPV Vaccine? Yes ☐ No ☐

2. Has this student received any vaccines outside Ireland?
If yes, please include a copy of their vaccine records with the returned consent form Yes ☐ No ☐

3. Has this student ever had as severe reaction to **anything** including medication or vaccine (including anaphylaxis)? Yes ☐ No ☐

4. Is the student currently taking any medication? Yes ☐ No ☐

Please detail _____

5. Does the student have any illness or condition that increases their risk of bleeding? Yes ☐ No ☐

Please detail _____

6A. Has this student had any serious illness in recent years? Yes ☐ No ☐

If yes, please read and tick this box if any of the below conditions apply for this student: ☐

- Haematopoietic stem cell also called stem cell transplant
- Solid organ transplant recipients for example kidney, lung or heart transplant patients or other organ transplant
- HIV infection
- Malignant haematological disorders affecting the bone marrow or lymphatic systems, for example leukaemia, lymphomas, blood dyscrasias
- Non-haematological malignant solid tumours (any cancer and malignancy other than blood cancer or cancer in the lymph system)
- Primary immunodeficiency including Down Syndrome (usually you are born with these conditions with a weak immune system)
- Within two weeks of commencing, on or within three to six months of receiving significant immunosuppressive therapy or medication.

A specialist will usually warn you the medication weakens your immune response and therefore potentially the response to vaccines. If you ticked yes for any boxes in question 6A for this student please answer question 6B

Students who have a weak immune system may need 3 doses of the HPV vaccine over 6 months. Healthy students only need one dose of HPV vaccine. If you think this student has any of these conditions listed in question 6A above please ask their Specialist/Consultant if they require 3 doses of HPV vaccine due to having a weak immune system. You can ask their Specialist/Consultant to visit www.immunisation.ie for further information to help with this discussion. If this student does not have a consultant, you can check with their GP or the school immunisation team. Then, tell the vaccination team when they attend vaccination appointment at school or tick the box below if they need 3 doses advised by their specialist.

6B. This student was advised by their treating Specialist/Consultant that they should have 3 doses of HPV vaccine due to having a weak immune system. Yes ☐ No ☐

FOR OFFICE USE ONLY

Name: Date of Birth:

Class: School Roll Number: PID:

Part 4: Immunisation Consent

Medical Consent: Please note only a parent or legal guardian can provide consent for a medical procedure, or refuse consent for a medical procedure for young people under 16 years of age. Young people aged 16 years or older are legally entitled to consent for themselves. Read more about the HSE Consent Policy on the HSE website.

CONSENT TO VACCINATION:

Please tick the box for each vaccine indicating whether you consent (tick yes) or refuse (tick no), and then sign the section.

HPV	Yes ☐	No ☐
Tdap	Yes ☐	No ☐
MenACWY	Yes ☐	No ☐

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 (Tick this box **only** if the person being vaccinated has a healthy immune system). ☐

For those advised 3 doses of HPV ONLY complete this option if the Specialist/Consultant treating the person being vaccinated has advised 3 doses of HPV vaccine are needed due to immunocompromised/a weak immune system. Please tick the box for those recommended three doses of the HPV by a specialist doctor.

I understand that I am giving consent for the administration of 3 doses of HPV vaccine over 6 months. ☐

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

Name *(Please print)*:

Signature: ______________________

Date: D D M M Y Y Y Y

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

Thank you for completing the consent form. Please return in the envelope provided.

Privacy Notice: The HSE do not use consent as a lawful basis for processing personal data. In the interest of transparency, to explain how we collect and use personal information the HSE provides details within the HSE Privacy Notice for Patients and Service Users which is accessible via the HSE Privacy Statement. 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:

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Name: Date of Birth:

Class: School Roll Number: PID:

VISIT 1 HPV (Dose one) + Tdap + MenACWY

This young person assents to receiving the vaccine (Please tick) ☐

HPV Dose	Date Given	Batch No.	Expiry Date	Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Injection Site (Circle as appropriate)	
1	D D M M Y Y Y Y		M M Y Y Y Y			Right Deltoid	Left Deltoid

Time Vaccinated: **AM/PM** | Vaccination Location: School ☐ Clinic ☐ | Clinic Name:

This young person assents to receiving the vaccine (Please tick) ☐

Tdap Dose	Date Given	Batch No.	Expiry Date	Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Injection Site (Circle as appropriate)	
	D D M M Y Y Y Y		M M Y Y Y Y			Right Deltoid	Left Deltoid

Time Vaccinated: **AM/PM** | Vaccination Location: School ☐ Clinic ☐ | Clinic Name:

This young person assents to receiving the vaccine (Please tick) ☐

Men-ACWY Dose	Date Given	Batch No.	Expiry Date	Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Injection Site (Circle as appropriate)	
	D D M M Y Y Y Y		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

This young person assents to receiving the vaccine (Please tick) ☐

HPV Dose	Date Given	Batch No.	Expiry Date	Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Injection Site (Circle as appropriate)	
2	D D M M Y Y Y Y		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

This young person assents to receiving the vaccine (Please tick) ☐

HPV Dose	Date Given	Batch No.	Expiry Date	Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Injection Site (Circle as appropriate)	
3	D D M M Y Y Y Y		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 _____