

Queensland School Immunisation Program

Vaccination Consent card – Year 7



Please return this card to your child's school – 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
Medicare number	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"/> Not stated/unknown
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 severe allergies
 - faints when given an injection
 - has recently received any vaccines
 - is immunocompromised
(check the HPV section in the Information Sheet)
 - is pregnant

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 human papillomavirus (HPV) and diphtheria, tetanus and pertussis (dTpa) 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 I understand that consent can be withdrawn at any time before vaccination by making a written request to the school immunisation provider.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 this information may be used by Queensland Health and the school immunisation provider for recall, reminders, clinical 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:

Human papillomavirus vaccine (HPV)

On the basis of the above consent statement,

YES I hereby give consent for my child to receive 2 doses of human papillomavirus vaccine.

Dose 1 Dose 2

Parent/legal guardian/authorised person

Signature _____

Date / / 20

Office use only: consent checked Dose 1 Dose 2

Diphtheria, tetanus and pertussis (whooping cough) vaccine (dTpa)

On the basis of the above consent statement,

YES I hereby give consent for my child to receive a single dose of the combined diphtheria, tetanus and pertussis vaccine.

Parent/legal guardian/authorised person

Signature _____

Date / / 20

Office use only: consent checked Dose 1

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 vaccination/s for your child in the School Immunisation Program, please complete the information below, sign and return to your child's school.

Student's Name _____

Date of Birth / / 20

Human papillomavirus vaccine (HPV)

NO, I do not give consent for my child to receive 2 doses of human papillomavirus vaccine.

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

My child has already received HPV vaccination Yes No

Other _____

Signature _____ Date / / 20

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

Diphtheria, tetanus and pertussis (whooping cough) vaccine (dTpa)

NO, I do not give consent for my child to receive a single dose of the combined diphtheria, tetanus and pertussis vaccine.

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

My child has already received dTpa vaccination Yes No

Other _____

Signature _____ Date / / 20

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

DO NOT DETACH

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
HPV Dose 1 Pre-vaccination assessment <input type="checkbox"/>	/ / 20	:	<input type="checkbox"/> L <input type="checkbox"/> R		
	<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		
HPV Dose 2 6-12 months after dose 1 Pre-vaccination assessment <input type="checkbox"/>	/ / 20	:	<input type="checkbox"/> L <input type="checkbox"/> R		
	<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		
dTpa (record as dose 5) Pre-vaccination assessment <input type="checkbox"/>	/ / 20	:	<input type="checkbox"/> L <input type="checkbox"/> R		
	<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
