YEAR 7 ACT HIGH SCHOOL IMMUNISATION PROGRAM 2020
CONSENT CARD

OFFICE USE ONLY: Complete details or affix label

URN: .....

Family Name: .....

Given Names: .....

DOB: ..... Sex: .....

Parent/Guardian to complete **all** fields in **CAPITAL** letters using a **black** or **blue** pen.

STUDENT DETAILS

Surname

Given and Middle Name/s

Date of Birth / /

Gender ☐ Male ☐ Female ☐ Other

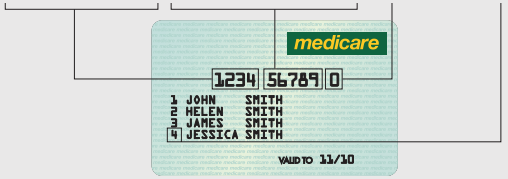
Country of Birth

Residential Address

Postcode

Name of School

Medicare Number



Number beside your child's name on the Medicare Card

INDIGENOUS STATUS

☐ No ☐ Yes, Aboriginal

☐ Yes, Torres Strait Islander

☐ Yes, both Aboriginal and Torres Strait Islander

☐ Decline to answer

PREFERRED LANGUAGE

☐ English ☐ Other

YOUR DETAILS – PARENT OR LEGAL GUARDIAN

Name of Parent/Legal Guardian (e.g. JACK SMITH)

I have legal parental responsibility of this child as: ☐ Parent ☐ Legal Guardian

Mobile Number

Best Alternative Number

PRE-VACCINATION CHECKLIST*

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

- ☐ has ever fainted when given an injection
- ☐ has received a vaccine in the last 4 weeks
- ☐ has any severe allergies
- ☐ has a Severe Allergy/Anaphylaxis Care Plan
- ☐ has previously had a reaction to a vaccine
- ☐ is pregnant or breastfeeding
- ☐ has a medical condition (e.g. epilepsy, asthma, diabetes, including previous Guillian-Barre syndrome and blood borne illness)

If you have ticked any box above, please describe: .....

.....

*This consent card may be viewed by school staff. If there is any sensitive information you wish to confidentially discuss with nursing staff, please contact the School Health Team on 02 5124 1585.

PARENT OR LEGAL GUARDIAN CONSENT

I have read and understood the information provided regarding the benefits and possible side effects of the **dTpa vaccine** and **HPV vaccine** and note that I can **withdraw consent** at any time.

Diphtheria-Tetanus-Pertussis (dTpa) Vaccine

☐ **Yes** I give consent for my child to receive the dTpa vaccine.

Signature **Date**

☐ **No** I do not consent for my child to receive the dTpa vaccine.

☐ **No** my child has already received the dTpa vaccine.

Signature **Date**

Human Papillomavirus (HPV) Vaccine

☐ **Yes** I give consent for my child to receive the HPV vaccine.

Signature **Date**

☐ **No** I do not consent for my child to receive the HPV vaccine.

☐ **No** my child has already received the HPV vaccine.

Signature **Date**

Once completed please return to your child's school as soon as possible. Thank you.

RECORD OF VACCINATION OFFICE USE ONLY THIS SIDE

OFFICE USE ONLY

HPV Dose 1

Vaccine Batch Number | Dose Date (DD/MM/YYYY) | Time of Vaccination (24 Hour) : | ☐ Left Arm ☐ Right Arm | Nurse's Signature, Name & Designation | ☐ AIR

HPV Dose 2

Vaccine Batch Number | Dose Date (DD/MM/YYYY) | Time of Vaccination (24 Hour) : | ☐ Left Arm ☐ Right Arm | Nurse's Signature, Name & Designation | ☐ AIR

dTpa

Vaccine Batch Number | Dose Date (DD/MM/YYYY) | Time of Vaccination (24 Hour) : | ☐ Left Arm ☐ Right Arm | Nurse's Signature, Name & Designation | ☐ AIR

NURSE'S NOTES