

1. Parent/Legal Guardians to complete BOTH sides of card 2. Tick the relevant boxes below, SIGN and RETURN this card to the school

Student name:

Diphtheria, tetanus, whooping cough booster

YES

I consent for this student to receive the adolescent booster dose of the diphtheria, tetanus and whooping cough vaccine (Boostrix®). This is in addition to all other childhood doses.

Parent/Legal Guardian signature: _____

Date: ____ / ____ / ____

SIGN HERE

Comments

NO

I do not consent for this student to receive the Boostrix® vaccine.
 This student has already received the adolescent booster dose of diphtheria, tetanus and whooping cough vaccine on: ____ / ____ / ____

Parent/Legal Guardian signature: _____

Date: ____ / ____ / ____

SIGN HERE

Human papillomavirus (HPV)

YES

I consent for this student to receive 2 doses of the HPV vaccine (Gardasil®9).

Parent/Legal Guardian signature: _____

Date: ____ / ____ / ____

SIGN HERE

Comments

NO

I do not consent for this student to receive the Gardasil®9 vaccine.
 This student has already received the HPV vaccine on:

1) ____ / ____ / ____ 2) ____ / ____ / ____ and

3) ____ / ____ / ____

Parent/Legal Guardian signature: _____

Date: ____ / ____ / ____

SIGN HERE

Office Use Only (Parent/Legal Guardians/Student DO NOT COMPLETE)

Boostrix®

Student ID and consent verified

Date: / /

Time: Batch No:

L arm

R arm Given by:

Gardasil®9 Dose 1

Student ID and consent verified

Date: / /

Time: Batch No:

L arm

R arm Given by:

Gardasil®9 Dose 2

Student ID and consent verified

Date: / /

Time: Batch No:

L arm

R arm Given by:

2022 Year 8 SA School Immunisation Program Consent Card



Government
of South Australia

SA Health

1. Parent/Legal Guardian to complete ALL details fully using blue or black pen in BLOCK LETTERS
2. Complete BOTH sides of card
3. RETURN card to the school

Year 8 student details

Name of School
Class (Home Room, Colour, etc)
Legal Family Name
Legal Given Name(s)
Date of Birth / / Age Male Female Prefer not to say
Medicare number Reference number next to student's name
Main language spoken at home

Postal address

Suburb Postcode
Aboriginal and Torres Strait Islander Aboriginal Torres Strait Islander Neither

Consenting Parent/Legal Guardian details

Mr / Mrs / Miss / Ms (please circle)
Family Name
Given Name(s)
Relationship to Student Parent Legal Guardian
Contact Phone (Home) (Mobile)
(Work)
Email
*Email and phone numbers may be used to clarify information if required.
You may receive an SMS as part of monitoring vaccine safety. Please tick in the box if you do NOT want to receive SMS for this reason*

Alternative emergency contact (school hours only)

Name
Relationship to child Contact Phone (Home)
(Mobile) (Work)

Year 8 pre-vaccination checklist

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

- | | |
|---|---|
| <input type="checkbox"/> has previously had a reaction to a vaccine | <input type="checkbox"/> is pregnant |
| <input type="checkbox"/> has ever fainted when given an injection | <input type="checkbox"/> has a bleeding disorder |
| <input type="checkbox"/> is taking any medication | <input type="checkbox"/> has lowered immunity (eg leukaemia, cancer, HIV/AIDS, radiotherapy, chemotherapy or oral steroids) |
| <input type="checkbox"/> has any allergies/Allergy Plan | |

Please describe

Before vaccination, the nurse will ask the student about the above information and **must be informed of any changes** as it may be several weeks or more between completing this card and receiving the vaccine(s).

Parent/Legal Guardians please read the following before completing the consent section on the other side of this card.

- I have read and understood the information on the Year 8 Parent/Legal Guardian Information Sheet including the risk of vaccination and the risk of diphtheria, tetanus, whooping cough and human papillomavirus (HPV).
- I understand that I can contact my School Immunisation Program provider to discuss these risks and benefits.
- I understand that I can withdraw consent at any time before vaccination takes place by contacting the School Immunisation Program provider.
- I understand the information provided on the Consent Card, and information related to vaccines administered will be stored electronically and/or in hard copy as a medical record. I consent to disclosure of this information to staff involved in the provision of an immunisation service for SA Health and local government councils and their immunisation providers. I understand that immunisation records will be recorded on the Australian Immunisation Register where it will be stored on my child's Medicare account.
- I understand I may receive an SMS as part of monitoring vaccine safety, unless I have opted NOT to receive SMS.

Please complete the required information over the page

OFFICIAL: Sensitive/Medical in confidence

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