

2023 Year 10 SA School Immunisation Program Consent Card



Government of South Australia

SA Health

1. Please complete this form even if not consenting, and select “do not consent’ over the page.
2. Complete ALL details fully using blue or black pen in BLOCK LETTERS
3. Complete BOTH sides of card
4. RETURN card to the school

Year 10 student details

Name of School.....

Class (Home Room, Colour, etc)

Legal Family Name.....

Legal Given Name(s).....

Date of Birth/...../..... Age.....

Male Female Another term 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

Parent/Legal Guardian details

Mr / Mrs / Miss / Ms (please circle)

Family Name.....

Given Name(s).....

Relationship to Student Parent Legal Guardian

Contact Phone (Home/Work).....(Mobile).....

Email

Email and phone numbers may be used to clarify information if required.

Alternative emergency contact (school hours only)

Name

Relationship to child Contact Phone (Home/Work).....

(Mobile)

Year 10 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).

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 10 Parent/Legal Guardian Information Sheet including the risk of vaccination and the risk of meningococcal A, B, C, W and Y disease.
- 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.
- Students may consent for themselves if they are aged 16 years and over.

Please complete the required information over the page

OFFICIAL: Sensitive//Medical in confidence

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1. Complete BOTH sides of card 2. Tick the relevant boxes below, SIGN and RETURN this card to the school

Student name:.....

Meningococcal B vaccine

Meningococcal ACWY vaccine

YES

I consent for this student to receive 2 doses of the meningococcal B vaccine (Bexsero®).

YES

I consent for this student to receive the meningococcal ACWY vaccine (Nimenrix®).

Parent/Legal Guardian signature: (Student may sign if aged 16 years or over)

Parent/Legal Guardian signature: (Student may sign if aged 16 years or over)

SIGN HERE

Date: ____ / ____ / ____

SIGN HERE

Date: ____ / ____ / ____

Comments

Comments

NO

I do not consent for this student to receive the Bexsero® vaccine.
 This student has already received a course of meningococcal B vaccine:
 Bexsero® on: ____ / ____ / ____ OR
 Trumenba® on: ____ / ____ / ____

NO

I do not consent for this student to receive the Nimenrix® vaccine.
 This student has already received the meningococcal ACWY vaccine:
(Menactra®, Menveo® or Nimenrix®) on: ____ / ____ / ____
(If the student received a meningococcal ACWY vaccine before 14 years of age, they require another dose now)

Parent/Legal Guardian signature: (Student may sign if aged 16 years or over)

Parent/Legal Guardian signature: (Student may sign if aged 16 years or over)

SIGN HERE

Date: ____ / ____ / ____

SIGN HERE

Date: ____ / ____ / ____

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

Bexsero® Dose 1

Bexsero® Dose 2

Nimenrix®

Student ID and consent verified

Student ID and consent verified

Student ID and consent verified

Date: / /

Date: / /

Date: / /

Time: Batch No:.....

Time: Batch No:.....

Time: Batch No:.....

L arm

L arm

L arm

R arm Given by:

R arm Given by:

R arm Given by: