

Student details

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

| School | Pre-vaccination checklist (tick all that apply) | |
|--|---|--------|
| Surname | My child ☐ has previously had a reaction to a vaccine ☐ has severe allergies | |
| Given name/s | ☐ faints when given an injection ☐ has recently received any vaccines ☐ is immunocompromised | |
| Date of birth 2 0 Female Male | (check the HPV section in the Information Sheet) ☐ is pregnant | |
| Medicare number Ref no. beside your child's name on the Medicare card | If you have ticked any box above, please give details: | |
| s your child | Note: you may be contacted for further information. | |
| Aboriginal Torres Strait Islander (TSI) Aboriginal & TSI Not Aboriginal or TSI Not stated/unknown | Consent statement | |
| Language spoken at home English Other | I have read and understood the information given to me about human papillomavirus (HPV) and diphtheria, tetanus pertussis (dTpa) vaccination, including risks and side effects. I have been given the opportunity to discuss the risks a | |
| please specify | benefits of vaccination with my doctor or by telephoning 13 HEALTH (13 43 25 84). I am authorised as the parent, leguardian or authorised person of this child to give consent for the child to be vaccinated. I understand that consent of | can be |
| Address | withdrawn at any time before vaccination by making a written request to the school immunisation provider. I underst vaccination details will be recorded on the Australian Immunisation Register (AIR) and this information may be used I Queensland Health and the school immunisation provider for recall, reminders, clinical follow up; or disease preventi | by |
| Postcode | control and monitoring; or as otherwise authorised by or required by law. | 1011, |
| | Please sign and date EACH vaccine you wish your child to receive: | |
| Parent / legal guardian / authorised person details | | |
| Name of parent/ egal guardian/ authorised person | Human papillomavirus vaccine (HPV) On the basis of the above consent statement, | orcon |
| | | EISUII |
| | YES I hereby give consent for my | erson |
| Mobile | child to receive 2 doses of human | |
| | child to receive 2 doses of human papillomavirus vaccine. Date / / 20 | |
| Mobile | child to receive 2 doses of human papillomavirus vaccine. Dose 1 Dose 2 D Office use only: consentchecked Dose 1 D | |
| Other phone number Email Relationship to student Parent Legal guardian Authorised person | child to receive 2 doses of human papillomavirus vaccine. Dose 1 ☑ Dose 2 ☑ Diphtheria, tetanus and pertussis Parent/legal guardian/authorised pertussis | Dose 2 |
| Mobile Other phone number Email | Thereby give consent for my child to receive 2 doses of human papillomavirus vaccine. Dose 1 ☑ Dose 2 ☑ Diphtheria, tetanus and pertussis (whooping cough) vaccine (dTpa) On the basis of the above consent statement, Signature Date / / 20 Parent/legal guardian/authorised per Signature | Dose 2 |
| Mobile Other phone number Email Relationship to student Parent Legal guardian Authorised person (attach Authority to Care) Is your address the same as your child Yes No | child to receive 2 doses of human papillomavirus vaccine. Dose 1 ☑ Dose 2 ☑ Diphtheria, tetanus and pertussis (whooping cough) vaccine (dTpa) Date / / 20 Office use only: consent checked Dose 1 ☑ D Parent/legal guardian/authorised per | Dose 2 |
| Other phone number Email Relationship to student Parent Legal guardian Authorised person (attach Authority to Care) Is your address the same as your child Yes No If NO please record your address | Thereby give consent for my child to receive 2 doses of human papillomavirus vaccine. 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 Date / / 20 Parent/legal guardian/authorised per Signature | erson |

| Record of vaccinatio | n | | | | | PID no. |
|---|------------------|------------------|----------------------------|----------------|--------------|-------------------------------|
| Name of Student | | | | | | * |
| Surname | | | | | | |
| Given Names | | | | | | |
| OFFICE USE ONLY Vaccine | Data of vessions | ion (dd/mm/yyyy) | Time of vaccination (24hr) | Arm | Batch number | Vessinatoria signatura (stama |
| Vaccine | Date of Vaccinat | ion (dd/mm/yyyy) | Time of vaccination (24m) | Arm | Batch number | Vaccinator's signature/stamp |
| HPV Dose 1 | /_ | / 20 | | LR | | |
| Pre-vaccination assessment | Absent | Refused | Unwell Cons | sent withdrawn | AEFI Other | , |
| HPV Dose 2 6-12 months after dose 1 | / | / 20 | | LR | | |
| Pre-vaccination assessment | Absent | Refused | Unwell Cons | sent withdrawn | AEFI Other | |
| dTpa (record as dose 5) | /_ | / 20 | | L R | | |
| Pre-vaccination assessment | Absent | Refused | Unwell Cons | sent withdrawn | AEFI Other | |
| Date Va | ccinator notes | | | | | |
| | | | e) | | 41 | |
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| | | | 19,0 | | | |

Office use only:

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

WILLING WOT DETACH WILLIAM DO NOT DETACH

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.

| ate of Birth / / 20 | |
|--|---------------------------------------|
| Human papillomavirus vaccine (HPV) | |
| NO , I do not give consent for my child to receive 2 doses of hi | uman 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) | |
| | igh) vaccine (dTpa) |
| Diphtheria, tetanus and pertussis (whooping country to consent for my child to receive a single dose tetanus and pertussis vaccine. | |
| Diphtheria, tetanus and pertussis (whooping cou NO , I do not give consent for my child to receive a single dose | |
| Diphtheria, tetanus and pertussis (whooping cou NO , I do not give consent for my child to receive a single dose tetanus and pertussis vaccine. | e of the combined diphtheria, |
| NO , I do not give consent for my child to receive a single dose tetanus and pertussis vaccine. I have planned my child's vaccination with my family doctor | e of the combined diphtheria, Yes No |
| Diphtheria, tetanus and pertussis (whooping cou NO , I do not give consent for my child to receive a single dose tetanus and pertussis vaccine. I have planned my child's vaccination with my family doctor My child has already received dTpa vaccination | e of the combined diphtheria, Yes No |

