2024 Year 7 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. Parent/Legal Guardian to complete ALL details fully using blue or black pen in BLOCK LETTERS
3. Complete BOTH sides of card 4. RETURN card to the school (even if not consenting)

Year 7 student details

Name of School .....

Class (Home Room, Colour, etc) .....

Legal/Official Family Name .....

Legal/Official Given Name(s) .....

Date of Birth ...../...../..... Age..... Preferred Name.....

Male ☐ Female ☐ Another term ☐ Prefer not to say ☐

Medicare number ☐☐☐☐ ☐☐☐☐☐ **Reference number next to student's name** ☐

OR

IHI number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Street address.....

Suburb ..... Postcode .....

Aboriginal and Torres Strait Islander ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither ☐

Main language spoken at home .....

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

(Mobile) .....

Year 7 pre-vaccination checklist

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

- ☐ has previously had a reaction to a vaccine
- ☐ has ever fainted when given an injection
- ☐ is taking any medication
- ☐ has any allergies/Allergy Plan
- ☐ is pregnant
- ☐ has a bleeding disorder
- ☐ has lowered immunity (e.g. leukaemia, cancer, HIV/AIDS, radiotherapy, chemotherapy or oral steroids)

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 7 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.

Please complete the required information over the page →

OFFICIAL: Sensitive//Medical in confidence

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: .....

Human papillomavirus (HPV)

YES

☐ **I consent** for this student to receive the HPV vaccine (**Gardasil®9**).

Parent/Legal Guardian signature:

SIGN HERE

_____ Date: ____ /____ /_____

Comments

_____

_____

_____

NO

☐ **I do not consent** for this student to receive the **Gardasil®9** vaccine.

☐ This student has already received the HPV vaccine on:

____ /____ /_____ at age _____ years

Parent/Legal Guardian signature:

SIGN HERE

_____ Date: ____ /____ /_____

Diphtheria, tetanus, whooping cough booster (dTpa)

YES

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

Parent/Legal Guardian signature:

SIGN HERE

_____ Date: ____ /____ /_____

Comments

_____

_____

_____

NO

☐ **I do not consent** for this student to receive the **Boostrix®/Adacel®** vaccine.

☐ This student has already received the **adolescent booster** dose of diphtheria, tetanus and whooping cough vaccine on: ____ /____ /_____

at age _____ years

Parent/Legal Guardian signature:

SIGN HERE

_____ Date: ____ /____ /_____

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

Gardasil®9

☐ Student ID and consent verified

Date: ..... /..... /.....

Time: ..... Batch No:.....

☐ L arm

☐ R arm Given by:. .....

Boostrix® / Adacel® (circle vaccine given)

☐ Student ID and consent verified

Date: ..... /..... /.....

Time: ..... Batch No:.....

☐ L arm

☐ R arm Given by:..... .....