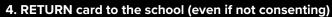
2024 Year 7 SA School Immunisation Program Consent Card

- 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

(Mobile)





Year 7 student details	Year 7 pre-vaccination checklist	
Name of School	Please tick the appropriate box(es) if the student:	
Class (Home Room, Colour, etc)	has previously had a reaction to a vaccine	is pregnant
Legal/Official Family Name	has ever fainted when given an injection	has a bleeding disorder
Legal/Official Given Name(s)	is taking any medication	has lowered immunity (e.g. leukaemia, cance HIV/AIDS, radiotherapy, chemotherapy or
	has any allergies/Allergy Plan	oral steroids)
Date of Birth/ Age Preferred Name	Please describe	
Male Female Another term Prefer not to say		
Medicare number Reference number next to student's name		oout the above information and must be informed of ar en completing this card and receiving the vaccine(s).
OR IHI number	Parent/Legal Guardians please read the	e following before completing the consent
Street address	section on the other side of this card.	, j
Suburb	 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 	
Contact Phone (Home/Work)(Mobile)		
Email Email and phone numbers may be used to clarify information if required.	child's Medicare account.	on negister where it will be stored off filly
Alternative emergency contact (school hours only) Name	Please complete the required information	on over the page
Relationship to StudentContact Phone (Home/Work)	OFFICIAL: Sensitive//Medical in confidence	@() \$=

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1. Parent/Legal Guardians to complete BOTH sides of card 2. Tick the relevant boxes below, SIGN and RETURN this card to the school			
Stu	dent name:		
Hum	an papillomavirus (HPV)	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.	
SIGN HERE	Parent/Legal Guardian signature: Date:/	Parent/Legal Guardian signature: SIGN HERE Date://	
Comme	ents	Comments	
NO SIGN HERE	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: Date:/	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://	
Office Use Only (Parent/Legal Guardians/Student DO NOT COMPLETE)			
	Gardasil®9	Boostrix® / Adacel® (circle vaccine given)	
	Student ID and consent verified	Student ID and consent verified	
	Date: /	Date://	
	Time: Batch No:	Time: Batch No:	
	L arm	L arm	
	R arm Given by:	R arm Given by:	