Queensland School Immunisation Program

Vaccination Consent card – Year 7

Queensland Government

Please return this card to your child's school with all information required – *print clearly using a black or blue pen*

Student details

School | Class

Surname

Given name/s

Date of birth / / 20 | ☐ Female ☐ Male

Medicare number **(must be completed)** | Ref no. beside your child's name on the Medicare card

Is your child

☐ Aboriginal ☐ Torres Strait Islander (TSI) ☐ Aboriginal & TSI
☐ Not Aboriginal or TSI ☐ Not stated/unknown

Language spoken at home ☐ English ☐ Other _____
please specify

Address

Postcode

Parent / legal guardian / authorised person details

Name of parent/ legal guardian/ authorised person

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
If NO please record your address

Address

Postcode

Pre-vaccination checklist *(tick all that apply)*

My child

☐ has previously had a reaction to a vaccine
☐ faints when given an injection
☐ is immunocompromised *(check the HPV section in the Information Sheet)*
☐ has severe allergies
☐ has recently received a vaccine/s
☐ is pregnant

If you have ticked any box above, please give details: _____

Note: you may be contacted for further information.

Consent statement

I have read and understood the information given to me about human papillomavirus (HPV) and diphtheria, tetanus and pertussis (dTpa) vaccination, including risks and side effects. I have been given the opportunity to discuss the risks and benefits of vaccination with my doctor or by telephoning 13 HEALTH (13 43 25 84). *I am authorised as the parent, legal guardian or authorised person of this child to give consent for the child to be vaccinated. I understand that consent can be withdrawn at any time before vaccination by making a written request to the school immunisation provider. I understand vaccination details will be recorded on the Australian Immunisation Register (AIR) and this information may be used by Queensland Health and the school immunisation provider for recall, reminders, clinical follow up; or disease prevention, control and monitoring; or as otherwise authorised by or required by law.*

Please sign and date EACH vaccine you wish your child to receive:

Human papillomavirus vaccine (HPV)
On the basis of the above consent statement,

YES I hereby give consent for my child to receive 2 doses of human papillomavirus vaccine.

Dose 1 ☑ Dose 2 ☑

Parent/legal guardian/authorised person

Signature

Date / / 20

Office use only: consent checked 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 to receive a single dose of the combined diphtheria, tetanus and pertussis vaccine.

Parent/legal guardian/authorised person

Signature

Date / / 20

Office use only: consent checked Dose 1 ☐

DO NOT DETACH

DO NOT DETACH

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 Government

Queensland School Immunisation Program
No to vaccination

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.

Student's Name

Date of Birth / / 20

School

Human papillomavirus vaccine (HPV)

NO, I do not give consent for my child to receive 2 doses of human 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*)

Diphtheria, tetanus and pertussis (whooping cough) vaccine (dTpa)

NO, I do not give consent for my child to receive a single dose of the combined diphtheria, tetanus and pertussis vaccine.

I have planned my child's vaccination with my family doctor ☐ Yes ☐ No

My child has already received dTpa vaccination ☐ Yes ☐ No

Other

Signature Date / / 20

Parent/legal guardian/authorised person (attach *Authority to Care*)

Office use only:

PID no.

Record of vaccination

Name of Student

Surname

Given Names

OFFICE USE ONLY

Vaccine	Date of vaccination (dd/mm/yyyy)	Time of vaccination (24hr)	Arm	Batch number	Vaccinator's signature/stamp
HPV Dose 1	/ / 20	:	☐ L ☐ R		
Pre-vaccination assessment ☐	☐ Absent ☐ Refused	☐ Unwell ☐ Consent withdrawn		☐ AEFI ☐ Other	
HPV Dose 2 6-12 months after dose 1	/ / 20	:	☐ L ☐ R		
Pre-vaccination assessment ☐	☐ Absent ☐ Refused	☐ Unwell ☐ Consent withdrawn		☐ AEFI ☐ Other	
dTpa	/ / 20	:	☐ L ☐ R		
Pre-vaccination assessment ☐	☐ Absent ☐ Refused	☐ Unwell ☐ Consent withdrawn		☐ AEFI ☐ Other	

Date	Vaccinator notes