2025 Year 10 SA School Immunisation Program Consent Card

- 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

(Mobile)

3. Complete BOTH sides of card 4. RETURN card to the school (even if not consenting)



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/ear 10 student details	Year 10 pre-vaccination checklist Please tick the appropriate box(es) if the student:	
Name of School	has previously had a reaction to a vaccine	is pregnant
egal/Official Family Name	has ever fainted when given an injection is taking any medication	has a bleeding disorder has lowered immunity (e.g. leukaemia, cancer,
.egal/Official Given Name(s)	has any allergies/Allergy Plan	HIV/AIDS, radiotherapy, chemotherapy or
Date of Birth/ Age Preferred Name	Please describe	oral steroids)
Male Female Another term Prefer not to say		
Medicare number Reference number next to student's name	Before vaccination, the nurse will ask the student abo any changes as it may be several weeks or more bet	out the above information and must be informed of tween completing this card and receiving the vaccine(s).
HI number	Please read the following before comple	eting the consent section on the
Street address	other side of this card.	
Suburb Postcode	 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. 	
Aboriginal and Torres Strait Islander Aboriginal Torres Strait Islander Neither		
Main language spoken at home	 I understand that I can contact my School these risks and benefits. 	ol Immunisation Program provider to discuss
Parent/Legal Guardian details	 I understand that I can withdraw consent at any time before vaccination takes place by contacting the School Immunisation Program provider. 	
Mr / Mrs / Miss / Ms (please circle)	·	n the Consent Card, and information related
amily Name	to vaccines administered will be stored of medical record. I consent to disclosure of	electronically and/or in hard copy as a of this information to staff involved in the
Given Name(s)	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 the	
Relationship to Student Parent Legal Guardian		
Contact Phone (Home/Work)(Mobile)	student's Medicare account.	S .
mail	Students can legally consent for themse	elves if they are aged 16 years and over.
Email and phone numbers may be used to clarify information if required.	Please complete the required informati	on over the page
Alternative emergency contact (school hours only)		,
Name	For more information	
Relationship to Student	Immunisation Section	OFFICIAL C. III (A. III III C. I



Communicable Disease Control Branch sahealth.sa.gov.au/schoolimmunisationprogram

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 ACWY vaccine	N	Meningococcal B vaccine		
YES Consent for this student to receive the meningood	YES	I consent for this student to receive 2 doses / or the adolescent booster dose of the meningococcal B vaccine, as clinically indicated*. *Determined by School Immunisation Provider assessment of previous vaccination history.		
Parent/Legal Guardian/Self (16 years and over) sign Please circle	SIGN			
HERE D	ate:/ HERE	Date:/		
I do not consent for this student to receive the ment of the student received a meningococcal ACWY vac they should have another dose now. Parent/Legal Guardian/Self (16 years and over) sign	If the student has received previous doses of meningococcal B vaccines before 14 years of age, they should have another dose now.			
SIGN HERED	SIGN HERE Date: Date:			
Comments		ments		
Office Use Only (Parent/Legal Guardians/Student DO NOT COMPLETE)				
Meningococcal ACWY vaccine	Meningococcal B vaccine Dose 1/	Meningococcal B vaccine Dose 2		
Student ID and consent verified	adolescent booster dose	Student ID and consent verified		
Date://	Student ID and consent verified	 Date://		
Time: Batch No:	Date: / / Batch No:	Time:Batch No:		
L arm	L arm	 L arm		
R arm Given by:	R arm Given by:	R arm Given by:		