

2026 Year 10 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. 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 10 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

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 10 pre-vaccination checklist

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

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

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).

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 10 Parent/Legal Guardian Information Sheet* including the risk of vaccination and the risk of meningococcal A, B, C, W and Y disease.
- 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 the student's Medicare account.
- Students can legally consent for themselves if they are aged 16 years and over.

Please complete the required information over the page



For more information

Immunisation Section
Communicable Disease Control Branch
sahealth.sa.gov.au/SIP

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

YES I consent for this student to receive the meningococcal ACWY vaccine.

Note: If the student has received a previous dose of meningococcal ACWY vaccine before 14 years of age, 1 further dose is required at school.

Parent/Legal Guardian/Self (16 years and over) signature:

Please circle

SIGN HERE _____ Date: ____ / ____ / ____

OR

NO I do not consent for this student to receive the meningococcal ACWY vaccine.

I would like to be contacted by the School Immunisation Program Provider to discuss further.

Parent/Legal Guardian/Self (16 years and over) signature:

SIGN HERE _____ Date: ____ / ____ / ____

Comments

Meningococcal B vaccine

YES I consent for this student to receive **2 doses** / or the adolescent booster dose of the meningococcal B vaccine, as clinically indicated.

Note: If the student has received any previous dose/s of meningococcal B vaccine before 14 years of age:

1 valid dose received – 2 further doses required at school.

2 valid doses received – 1 further dose required at school.

Parent/Legal Guardian/Self (16 years and over) signature:

Please circle

SIGN HERE _____ Date: ____ / ____ / ____

OR

NO I do not consent for this student to receive the meningococcal B vaccine.

I would like to be contacted by the School Immunisation Program Provider to discuss further.

Parent/Legal Guardian/Self (16 years and over) signature:

SIGN HERE _____ Date: ____ / ____ / ____

Comments

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

Meningococcal ACWY vaccine

Student ID and consent verified

Date: / /

Time: Batch No:

L arm

R arm Given by:

Meningococcal B vaccine

Dose 1 Dose 2 Dose 3

Student ID and consent verified

Date: / /

Time: Batch No:

L arm

R arm Given by:

Meningococcal B vaccine

Dose 2 Dose 3

Student ID and consent verified

Date: / /

Time: Batch No:

L arm

R arm Given by: