Government of **Western Australia**
Department of **Health**
Public and Aboriginal Health Division

Year 10 Meningococcal ACWY School Based Immunisation Program 2020

Dear Parent/Guardian

Please read all the enclosed information about the vaccines being offered to your child through the Meningococcal ACWY Immunisation Program, then complete this form in **capital letters and tick appropriate boxes (using black ink)** and return it to your child's school within the next week.

Student details. Please fill in this section whether you consent to your child receiving the vaccine or not

Student's last name

Student's first name

Middle initial

Student's date of birth — —

Gender M ☐ F ☐ U (Unspecified/Undetermined/Undisclosed) ☐

Aboriginal Yes ☐ No ☐

Medicare number (free service if provided at school, please ensure Medicare details are provided)

Reference number next to child's name ☐

Medicare card not available/shown ☐

Valid to ☐☐/☐☐☐☐

Name of school student attends

Parent/Legal guardian details. Please fill in this section whether you consent to your child receiving the vaccine or not

Relationship to student Father ☐ Mother ☐ Legal guardian ☐

Parent/Guardian legal last name

Parent/Guardian legal first name

Mobile phone (preferred)

Home phone

Work phone

Email

Parent/Guardian address (1) Address of individual filling in form (number and street)

Suburb

Postcode

Parent/Guardian address (2) Optional e.g. PO Box (number and street)

Suburb

Postcode

Consent section – parent/guardian to complete

- I am authorised to give consent or non-consent for my child to be vaccinated. I have read and understand the information provided about vaccination, including the possible vaccine side effects. I understand I can discuss the risks and benefits of vaccination with my GP or call the school immunisation nurse. Consent provided for the below-mentioned vaccines will remain valid until it is withdrawn by calling the school team as per number on the envelope.
- I understand I may receive an SMS from the WA Dept of Health about my child's vaccination experience in order to monitor vaccine safety.
- I understand the information provided on this form will be recorded on relevant State and Commonwealth immunisation registers. It will remain confidential and used to monitor immunisation rates and inform program improvement.

Please ensure you tick the green box for your child to be vaccinated.
If you do not want your child to receive the vaccine, tick the relevant red box.

Do you consent to your child receiving the meningococcal ACWY vaccine? Yes ☐ No ☐ Signature: ..... Date: .....

Has your child ever received the meningococcal ACWY vaccine (e.g. for travel)? Yes ☐ No ☐
If yes, provide details: .....

Has your child ever had a serious reaction to any vaccine? Yes ☐ No ☐
If yes, provide details: .....

Does your child have any severe allergies? Yes ☐ No ☐
If yes, provide details: .....

Does your child have any long term medical conditions (e.g. diabetes, epilepsy etc)? Yes ☐ No ☐
If yes, provide details: .....

Has your child fainted when receiving an injection? Yes ☐ No ☐
If yes, provide details: .....

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Immunisation provider comments

	Consent					Site: Left arm	Site: Right arm	Record entered in AIR
	Yes	No	Date given	Batch	Vaccinator			
Meningococcal ACWY								

Notes

Telephone consent: Office use only

Verbal consent for vaccination was given Yes ☐ No ☐ Time ..... : ..... Date ..... / ..... / .....

Signature ..... Signature .....

Name..... Name .....

Consent provided by (name) ..... Relationship to child ..... (e.g. father, mother)

Contact number .....

Data entry: AIR ☐ webPAS ☐ CHIS ☐ WINVAC ☐ MMEX ☐

Comments

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