



School-based Immunisation Program 2024

The School-based Immunisation Program provides routine and recommended vaccines to WA high school students for free. Students are eligible to receive the following vaccines in 2024:

Year 7: Diphtheria-tetanus-pertussis (dTpa) and Human papillomavirus (HPV)

Year 10: Meningococcal ACWY (Men ACWY)

Please read, sign and return the immunisation consent form to your student's school. Interpreter required: Yes No

Child's (dependent's) details. Please fill in this section whether you consent to your child receiving vaccines or not

Child's first name

Child's last name

Date of birth / /

Gender M F Undisclosed

Residential address

Suburb Postcode

Medicare number Reference number next to child's name Medicare card not available/shown School year group

Name of the school your child attends

Is your child a WA Health Staff member? Yes No

Does the child identify as Aboriginal and/or Torres Strait Islander descent?
 Aboriginal Torres Strait Islander Both
 Prefer not to say Neither

Mobile phone

Child does not have a mobile phone

Landline contact number

Parent/legal guardian details. Please fill in this section whether you consent to your child receiving vaccines or not

Do you have a VaccinateWA account? Yes No (if no, one will be created for you and your child)

Parent/guardian legal last name Parent/guardian first name

Parent/guardian date of birth / / Parent/guardian gender M F Undisclosed

Mobile phone (preferred) Landline contact number

Email

Residential address

Suburb Postcode

Medicare number Reference number Medicare card not available/shown

Do you identify as Aboriginal and/or Torres Strait Islander decent?
 Aboriginal Tores Strait Islander Both
 Prefer not to say Neither

Are you a WA Health Staff member? Yes No

Consent section – parent/guardian to complete

General

Has the person being vaccinated ever had a serious reaction to any vaccine? Yes No

Does the person being vaccinated have any severe allergies? Yes No

Does the person being vaccinated have any long term medical conditions (e.g. diabetes, epilepsy etc)? Yes No

Has the person being vaccinated fainted when receiving an injection? Yes No

Does the person being vaccinated have a disease that lowers their immunity or is receiving treatment that lowers their immunity? Yes No

Additional question for Year 10s only:

Has your child received the Meningococcal ACWY (MenACWY) vaccine in the last 12 months? Yes No

Note: Your child will need a dose of the MenACWY vaccine even if they received a Men C vaccine as an infant.

If you have answered Yes to any of the above questions, please provide additional information:

- I am the parent/guardian and 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 above-mentioned vaccine(s) will remain valid until 31st December 2025, and can be withdrawn by contacting the school team.
- 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.
- Do you give permission for WA Health to contact you by SMS to monitor vaccine safety and effectiveness?
Yes No

Please ensure you tick and sign the green boxes for your child to be vaccinated.

If you do not want your child to receive a specific vaccine, tick and sign the relevant red box.

Year 7	Diphtheria, tetanus and whooping cough (1 dose of adolescent booster dTpa vaccine)		
	Yes <input type="checkbox"/>	Signature: _____	Date: ____ / ____ / ____
	No <input type="checkbox"/>	Signature: _____	Date: ____ / ____ / ____
	Human Papillomavirus (1 dose of HPV vaccine)		
	Yes <input type="checkbox"/>	Signature: _____	Date: ____ / ____ / ____
	No <input type="checkbox"/>	Signature: _____	Date: ____ / ____ / ____
Year 10	Meningococcal ACWY (1 dose of menACWY vaccine)		
	Yes <input type="checkbox"/>	Signature: _____	Date: ____ / ____ / ____
	No <input type="checkbox"/>	Signature: _____	Date: ____ / ____ / ____

Immunisation provider comments

Vaccine	Consent		Date given	Batch	Vaccinator	Site: Left arm	Site: Right arm	Record entered in AIR
	Yes	No						
HPV								
dTpa								
MenACWY								
Other (specify)								

Notes (i.e. date AIR checked):

Office use only

Telephone consent:

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: VaccinateWA AIR webPAS CHIS WINVAC MMEX

Comments