

**School Based Immunisation Program
Vaccine Consent**

Please complete and return this form to school as soon as possible

Student Details as Recorded on Medicare Card

Student First Name:	Student Last Name:
Date of Birth:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to say	
Address:	
Medicare Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
<input type="checkbox"/> Non-Aboriginal <input type="checkbox"/> Aboriginal <input type="checkbox"/> Aboriginal and Torres Strait Islander <input type="checkbox"/> Torres Strait Islander	
School:	Year Level & Class:
Language Spoken at Home: <input type="checkbox"/> English <input type="checkbox"/> Other – please specify	
Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Parent / Legal Guardian / Authorised Person Details

First Name:	Last Name:
Phone Number:	Email:
Relationship to Student: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Authorised Person	

Pre-Vaccination Checklist – tick all that apply

<input type="checkbox"/> previously had a severe reaction to a vaccine	<input type="checkbox"/> lowered immunity (e.g. cancer, HIV, radiotherapy, chemotherapy, steroid treatment)
<input type="checkbox"/> allergies	<input type="checkbox"/> bleeding disorder
<input type="checkbox"/> medical conditions	<input type="checkbox"/> pregnant or may be pregnant

Provide details here:

Consent Statement

- I have read and understand the information on the pneumococcal & influenza vaccine fact sheets.
- I understand this consent form is valid until the vaccine course is complete or consent is withdrawn.
- I understand vaccination details will be recorded on the Australian Immunisation Register and NT Immunisation Register.

Privacy Statement

*The information on this form will be recorded on the Australian Immunisation Register (AIR) and immunisation records can be accessed through MyGov. All personal information collected and disclosed to AIR by NT Health will be handled in accordance with the Information Act 2002 (the Act) including requirements set by the Information Privacy Provisions (IPPS) at schedule 2 of the Act. NT Health takes all responsible steps to ensure the information we collect is stored securely, protecting it from misuse, loss, unauthorised access, modification or disclosure. All information disclosed to AIR(Cth) is subject to the Australian Immunisation Register 2015 and the Privacy Act 1988(Cth). For further information please contact 08 89992668 or email legal.health@nt.gov.au.

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Student Name:	DOB:	Year Level & Class:
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Pneumococcal Vaccine Consent available to all Aboriginal and Torres Strait Islander students from year 7		Influenza Vaccine Consent available to all Aboriginal and Torres Strait Islander students and students with medical risk, annually.	
<input type="checkbox"/> YES I give consent for my child to receive a single dose of the pneumococcal vaccine. Name: Signature: Date:	<input type="checkbox"/> YES I give consent for my child to receive a single dose of the influenza vaccine. Name: Signature: Date:	<input type="checkbox"/> NO I DO NOT give consent for my child to receive a single dose of pneumococcal vaccine. Name: Signature: Date: Already Vaccinated: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unsure	<input type="checkbox"/> NO I DO NOT give consent for my child to receive a single dose of influenza vaccine. Name: Signature: Date: Already Vaccinated: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unsure

Phone / Verbal Consent – for use by NURSE VACCINATOR ONLY			
Date:	Time:	Phone Number:	
Parent/Legal Guardian/Authorised Person Name:			
Relationship to Student:		Email:	
Verbal consent obtained for one dose pneumococcal vaccine			<input type="checkbox"/> YES <input type="checkbox"/> NO
Verbal consent obtained for one dose of influenza vaccine			<input type="checkbox"/> YES <input type="checkbox"/> NO
Staff Name:	Staff Signature:	Designation:	
Comments:			

Office Use ONLY					
AIR checked <input type="checkbox"/> Y <input type="checkbox"/> N			Date:	Initials:	
Vaccine & Dose	Date & Time Given	Batch Number	Site Arm	Vaccinator Name	CCIS
Pneumococcal dose 1			<input type="checkbox"/> Left <input type="checkbox"/> Right		
Influenza dose 1			<input type="checkbox"/> Left <input type="checkbox"/> Right		
Reason not vaccinated:					
Signature:				Date:	

For further information regarding the School Based Immunisation Program please contact Centre of Disease Control (CDC): Darwin 8922 8044 or Regional Centres: Katherine 8973 9049; Alice Springs 8951 7540; Nhulunbuy 8987 0357; Tennant Creek 8962 4259