2026 Year 7 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. Parent/Legal Guardian to 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 7 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 ☐

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 7 pre-vaccination checklist

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

- ☐ has previously had a reaction to a vaccine
- ☐ has ever fainted when given an injection
- ☐ is taking any medication
- ☐ has any allergies/Allergy Plan

Please describe

- ☐ is pregnant
- ☐ has a bleeding disorder
- ☐ has lowered immunity (e.g. leukaemia, cancer, HIV/AIDS, radiotherapy, chemotherapy or oral steroids)

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).

Parent/Legal Guardians 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 7 Parent/Legal Guardian Information Sheet* including the risk of vaccination and the risk of diphtheria, tetanus, whooping cough and human papillomavirus (HPV).
- 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.

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. Parent/Legal Guardians to complete BOTH sides of card 2. Tick the relevant boxes below, SIGN and RETURN this card to the school

Student name: .....

Human papillomavirus (HPV)

YES ☐ **I consent** for this student to receive the human papillomavirus (**HPV**) vaccine.

Parent/Legal Guardian signature:

SIGN HERE _____ Date: ____ /____ /_____

OR

NO ☐ **I do not consent** for this student to receive the human papillomavirus (**HPV**) vaccine.

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

Parent/Legal Guardian signature:

SIGN HERE _____ Date: ____ /____ /_____

Comments

Diphtheria, tetanus, whooping cough booster (dTpa)

YES ☐ **I consent** for this student to receive the **adolescent booster** dose of the diphtheria, tetanus and whooping cough (**dTpa**) vaccine.
This is in addition to all other childhood doses.

Parent/Legal Guardian signature:

SIGN HERE _____ Date: ____ /____ /_____

OR

NO ☐ **I do not consent** for this student to receive the diphtheria, tetanus, whooping cough (**dTpa**) vaccine.

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

Parent/Legal Guardian signature:

SIGN HERE _____ Date: ____ /____ /_____

Comments

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

Human papillomavirus (HPV) vaccine

☐ Student ID and consent verified

Date: ..... /..... /.....

Time: ..... Batch No:.....

☐ L arm

☐ R arm Given by:.....

Diphtheria, tetanus, pertussis (dTpa) vaccine

☐ Student ID and consent verified

Date: ..... /..... /.....

Time: ..... Batch No:.....

☐ L arm

☐ R arm Given by:.....