Government of **Western Australia**
Department of **Health**

EMR320330

Affix unique patient identification label in this box

Respiratory Syncytial Virus (RSV) Infant Immunisation Consent Form – for Community Health use

Please print clearly in capital letters using a blue or black ball point pen.

Infant's details

First name (if known) .....

Note: Where the baby has not been named, use the term '**Baby of**' as the first name. For a multiple birth, use '**Baby 1 of**', '**Baby 2 of**'.

Last name (use mother's surname) .....

Date of birth (DD/MM/YYYY) ...../...../.....

Sex: Male ◯ Female ◯ Indeterminate ◯ Medicare number (if known) .....

Parent or guardian's details

Person providing consent (select one): Mother ◯ Father ◯ Other (specify) .....

First name ..... Last name .....

Telephone number (mobile preferred) .....

Mother's address: same address as the mother's Medicare records.

.....

..... Postcode .....

Mother's address is required to record infant's immunisation in the Australian Immunisation Register.

Consent to administer nirsevimab (Beyfortus®)

- I have read and understood the information contained in the *Nirsevimab – What parents need to know* information sheet regarding the potential benefits and risks of nirsevimab. Yes ◯ No ◯
- I have had an opportunity to have my questions answered. Yes ◯ No ◯
- I acknowledge that a copy of this form will be sent to the WA Department of Health Immunisation Program and that my child's nirsevimab immunisation may be recorded on the Australian Immunisation Register. Yes ◯ No ◯

Consent to being contacted by the department for quality assurance purposes

As part of our ongoing efforts to continuously monitor program services and immunisation safety, the department is requesting permission to contact you about your child's immunisation experience and your perspectives on the WA RSV immunisation program. If you agree, you may be contacted by a staff member using the phone number recorded above. Your decision to participate in quality assurance follow-up is completely voluntary, separate from consent for RSV immunisation, and will not affect the care your child receives.

- I give my permission to be contacted by the department and asked about my child's immunisation experience and the WA RSV immunisation program. Yes ◯ No ◯
- If yes, please indicate the preferred method of contact SMS survey ◯ Phone call ◯ no preference ◯

Signature of parent/guardian ..... Date: ...../...../.....

Dose administered (select one)

◯ **Infant weighing less than 5 kg → 0.5 mL** (batch 2043111 or specify other .....)

◯ **Infant weighing 5 kg or more → 1.0 mL** (batch 2043117 or specify other .....)

◯ **Medically at-risk child aged 8 to 19 months → 2 x 1.0 mL** (batch 2043117 or specify other .....)

Site nirsevimab administered: left anterolateral thigh ◯ right anterolateral thigh ◯

Date nirsevimab administered ...../...../..... Name of hospital or immunisation clinic .....

Hospital/clinic phone number (landline preferred) .....

Name of person administering nirsevimab .....

Signature and designation (e.g. RN or RM) of person administering nirsevimab .....

Community Health – MR30.9N

IMM-014681 MAR'24