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

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: Diptheria-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 ☐

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

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

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 ☐

Do you identify as Aboriginal and/or Torres Strait Islander decent?

☐ Aboriginal ☐ Tores Strait Islander ☐ Both ☐ Prefer not to say ☐ Neither

Mobile phone (preferred)

Landline contact number

Email

Residential address

Suburb

Postcode

Medicare number ☐

Reference number ☐

Medicare card not available/shown ☐

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 ☐ Signature:_____ Date:_____ /_____ /_____

No ☐ Signature:_____ Date:_____ /_____ /_____

Human Papillomavirus (1 dose of HPV vaccine)

Yes ☐ Signature:_____ Date:_____ /_____ /_____

No ☐ Signature:_____ Date:_____ /_____ /_____

Year 10

Meningococcal ACWY (1 dose of menACWY vaccine)

Yes ☐ Signature:_____ Date:_____ /_____ /_____

No ☐ Signature:_____ Date:_____ /_____ /_____

For office use only

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

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