

# COVID-19 SA YOUTH VACCINATION CONSENT CARD



1. Parent/Legal Guardian to complete ALL details fully using blue or black pen in BLOCK LETTERS
2. Complete BOTH sides of card
3. RETURN card to the school/take completed form to COVID-19 Vaccination Clinic (if applicable)

## Student details

Name of School.....

Class (Home Room, Colour, etc) .....

Legal Family Name .....

Legal Given Name(s).....

Date of Birth ...../...../..... Age..... Male  Female  Prefer not to say

Medicare number  Reference number next to student's name

Main language spoken at home .....

Postal address .....

Suburb ..... Postcode.....

Aboriginal and Torres Strait Islander  Aboriginal  Torres Strait Islander  Neither

## Consenting Parent/Legal Guardian details

Mr / Mrs / Miss / Ms (please circle)

Family Name.....

Given Name(s) .....

Relationship to Student Parent  Legal Guardian

Contact Phone (Home).....(Mobile).....

(Work) .....

Email .....

Email and phone numbers may be used to clarify information if required.

## Alternative emergency contact (school hours only)

Name .....

Relationship to child .....Contact Phone (Home).....

(Mobile) .....(Work).....

## Student pre-vaccination checklist

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

- |   |  |
|---|--|
| <input type="checkbox"/> has previously had a reaction to a vaccine or any other medication                   | <input type="checkbox"/> has lowered immunity (eg leukaemia, cancer, HIV/AIDS, radiotherapy, chemotherapy or oral steroids)              |
| <input type="checkbox"/> has ever had anaphylactic reaction or/and any allergies/Allergy Plan                 | <input type="checkbox"/> has had COVID-19 before   |
| <input type="checkbox"/> has ever had myocarditis/pericarditis/endocarditis/heart failure or heart transplant | <input type="checkbox"/> has had a COVID-19 vaccine before   |
| <input type="checkbox"/> has ever had acute rheumatic fever or rheumatic heart disease                        | <input type="checkbox"/> has had a vaccine/s recently (a 7 day interval is recommended between a COVID-19 vaccine and any other vaccine) |
| <input type="checkbox"/> is taking any medication   | <input type="checkbox"/> is pregnant   |
| <input type="checkbox"/> has a bleeding disorder  | <input type="checkbox"/> has ever fainted when given an injection.   |

Please describe.....

Before vaccination, the vaccinator 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

Students may consent for themselves if they are aged 16 years and over.

- I have read and understood the information on the Student Parent/Legal Guardian Information Sheet including the risk of vaccination and the risk of COVID-19.
- I understand that I can contact my COVID-19 Vaccination Provider to discuss these risks and benefits.
- I understand that I can withdraw consent at any time before vaccination takes place by contacting the COVID-19 Vaccination 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 my child's Medicare account.
- I understand I may receive an SMS as part of monitoring vaccine safety.



Parent/Legal guardian to complete BOTH sides of the card. Tick the relevant box below and sign.

Student name:.....

## COMIRNATY™ (PFIZER) COVID-19 VACCINE

**YES**  
I consent for this student to receive **2 doses** of the Pfizer COVID-19 Vaccine

Parent/Legal Guardian signature:

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

**NO**  
I do not consent for this student to receive 2 doses of the Pfizer COVID-19 Vaccine

Parent/Legal Guardian signature:

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

Comments

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### OFFICE USE ONLY

#### COMIRNATY™ (PFIZER) COVID-19 VACCINE

Student ID and consent verified

#### DOSE 1

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

L arm       R arm

Given by:.....

#### COMIRNATY™ (PFIZER) COVID-19 VACCINE

Student ID and consent verified

#### DOSE 2

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

L arm       R arm

Given by:.....