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

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School-based Immunisation Program 2025

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:

Year 7: Diphtheria-tetanus-pertussis (dTpa) and human papillomavirus (HPV)
Year 10: Meningococcal ACWY (MenACWY)

Please read, sign and return the immunisation consent form to your child's school.

Is an interpreter required: ☐ Yes ☐ No If yes, which language is required

Additional needs required: people who speak limited or no English, or who are Deaf or hard of hearing, have the right to request access to language services when using WA Health services. This includes interpreting services, Auslan and translated health information.

If you need help completing this form, please email SBIP@health.wa.gov.au or call 9222 2486.

Child's (dependent's) details

Please fill in this section whether you consent to your child receiving vaccines or not.

Child's last name

Child's first name

☐ The individual only has a single name

Date of birth / /

Gender ☐ Male ☐ Female ☐ 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 phone

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 ☐ Unsure (if no, one will be created for you and your child)

Parent/legal guardian last name

Parent/legal guardian first name

☐ The individual only has a single name

Parent/legal guardian details (continued)

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

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

Parent/guardian gender

☐ Male ☐ Female ☐ Undisclosed

Parent/guardian date of birth / /

Mobile phone (preferred)

Landline contact phone

Email

Residential address (if different to child's 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

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

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, or by contacting the school immunisation team. Consent provided for the above-mentioned vaccine(s) will remain valid until 31 December 2025, and can be withdrawn by contacting the school team. For contact details, please visit healthywa.wa.gov.au/adolescentimmunisation
- 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: ____ / ____ / ____

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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)								

Has AIR been checked before vaccination? ☐ Yes ☐ No

Notes (i.e. date AIR checked):

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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. mother, father, guardian)

Contact phone

Data entry

☐ VaccinateWA ☐ AIR ☐ webPAS ☐ CHIS ☐ WINVAC ☐ MMEX

Comments

Produced by the Communicable Disease Control Directorate

healthywa.wa.gov.au/adolescentimmunisation

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