

Please complete and return this form to school as soon as possible

Student Details as Recorded on Medicare Card

Student First Name:	Student Last Name:
Date of Birth:	
Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to say
Address:	
Medicare Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
<input type="checkbox"/> Non-Aboriginal <input type="checkbox"/> Aboriginal <input type="checkbox"/> Aboriginal and Torres Strait Islander <input type="checkbox"/> Torres Strait Islander	
School:	Year Level & Class:
Language Spoken at Home: <input type="checkbox"/> English <input type="checkbox"/> Other – please specify	

Parent / Legal Guardian / Authorised Person Details

First Name:	Last Name:
Phone Number:	Email:
Relationship to Student: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Authorised Person	

Pre-Vaccination Checklist – tick all that apply

<input type="checkbox"/> previously had a severe reaction to a vaccine	<input type="checkbox"/> lowered immunity (e.g. cancer, HIV, radiotherapy, chemotherapy, steroid treatment)
<input type="checkbox"/> bleeding disorder	<input type="checkbox"/> allergies
<input type="checkbox"/> medical condition	<input type="checkbox"/> pregnant or may be pregnant

Provide details here:

Vaccine Recommendation

- Adolescents 14 years and over are recommended to receive 2 doses of meningococcal B vaccine 8 weeks apart, regardless of previous doses of meningococcal B vaccine received under 14 years of age.

Consent Statement

- I have read and understand the information on the meningococcal B vaccine fact sheet.
- I understand this consent form is valid until the vaccine course has been completed or consent is withdrawn.
- I understand vaccination details will be recorded on the Australian Immunisation Register and the NT Immunisation Register.

Privacy Statement

*The information on this form will be recorded on the Australian Immunisation Register (AIR) and immunisation records can be accessed through MyGov. All personal information collected and disclosed to AIR by NT Health will be handled in accordance with the Information Act 2002 (the Act) including requirements set by the Information Privacy Provisions (IPPs) at schedule 2 of the Act. NT Health takes all responsible steps to ensure the information we collect is stored securely, protecting it from misuse, loss, unauthorised access, modification or disclosure. All information disclosed to AIR(Cth) is subject to the Australian Immunisation Register 2015 and the Privacy Act 1988(Cth). For further information please contact 08 89992668 or legal.health@nt.gov.au

**School Based Immunisation Program
Vaccine Consent**

**Meningococcal B
VACCINATION**

Student Name:	DOB:	Year Level & Class:
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Meningococcal B Vaccine Consent
available to all students from year 9

<input type="checkbox"/> YES	<p>I give consent for my child to receive two doses of the meningococcal B vaccine, with minimal interval of 8 weeks between doses.</p> <p>Name: _____ Signature: _____ Date: _____</p>
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<input type="checkbox"/> NO	<p>I do not give consent for my child to receive two doses of the meningococcal B vaccine.</p> <p>Name: _____ Signature: _____ Date: _____</p> <p>Already Vaccinated: Y <input type="checkbox"/> N <input type="checkbox"/> Unsure <input type="checkbox"/></p>
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Phone / Verbal Consent – for use by NURSE VACCINATOR ONLY

Date:	Time:	Phone Number:
Parent/Legal Guardian/Authorised Person Name:		
Relation to Student:		Email:

Verbal consent obtained for two dose of meningococcal B vaccines, minimum of 8 weeks between doses	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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Staff Name:	Staff Signature:	Designation:
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Comments:

Office Use ONLY

AIR checked Y N Date: _____ Initials: _____

Vaccine & Dose	Date & Time Given	Batch Number	Site ARM		Vaccinator Name	CCIS
Meningococcal B dose 1			<input type="checkbox"/> Left	<input type="checkbox"/> Right		
Meningococcal B dose 2			<input type="checkbox"/> Left	<input type="checkbox"/> Right		

Reason not vaccinated: _____

Signature: _____ Date: _____

For further information regarding the School Based Immunisation Program please contact Centre of Disease Control (CDC): Darwin 8922 8044 or Regional Centres: Katherine 8973 9049; Alice Springs 8951 7540; Nhulunbuy 8987 0357; Tennant Creek 8962 4259