

Dear parents/carers

WA Country Health Service have asked schools to assist students access COVID-19 vaccinations at the local clinic. As a result, the school has been asked to arrange transport to and from the clinic at the Merredin Public Library, 22 Coronation St, Merredin.

If you would like your child to be vaccinated at this clinic, you will need to:

- 1. Complete the registration as per the instructions on VaccinateWA.
- 2. Download, complete, sign **and return** the Consent Form to school by <u>Friday</u>, <u>22 October 2021</u>.
- 3. Ensure your child brings (or has already returned) the Consent Form to school on the designated day of vaccination.

This Consent Form and Registration process will cover the excursion permission for bus transport under staff supervision, for the purpose of receiving their vaccination.

Permission will cover:

- Dose 1 (Monday 25, 26 and 27 October) and the follow up
- Dose 2 (Monday 22, 23 and 24 November).

All normal excursion conditions and expectations will apply during this vaccination process.

It is not mandatory for students to receive the COVID-19 Vaccination, and your child will not be vaccinated without your consent.

Please be aware that you are able to use this consent form to attend any vaccination clinic if you choose to have your child vaccinated at a different time or location.

Please contact the school office if you have any further questions.

Kind regards

Jarrad Ritchie Principal Merredin College 19 October 2021

learning close to home

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COVID-19 Vaccination Consent Form

Before completing this form make sure you have read the information sheet on the COVID-19 vaccine you will be receiving.

Shade Circles Correct Completely Incorre	t: Black Ink Only Black Ink Only										 [Please print neatly in capital letters										
Resident's Information: Provide information as completely as you can: all information will be kept confidential																						
First name																						
Last name																						
Date of birth (e.g. 05/08/1980)] / [/]					•									
Gender	O Male	e OF	emale	0	Undi	sclos	ed	0	No	n-bir	nary											
Do you identify as Aboriginal and/or Torres Strait Islander?																						
	O No	O Ye	s, Abori	ginal	0	Yes,	Tori	res S	Strait	Isla	nder	(О В	oth	0	Pret	fer n	ot to	o say	,		
Telephone number (mobile preferred)]														
Email address																						
Medicare number	Medicare number (including individual reference number)																					
Residential address																						
Suburb																Pos	tcod	le				
Next of kin (in case of em	ergency)																			<u> </u>	
Name		, 																				
Contact number																						
oonaact number																						
Health Questionnaire																						
Have you previously r	eceived	the CO	/ID-19	vaccir	ne?		0	Yes	0	No												
State								Cour	ntry													
How many doses did y	/ou recei	ive?																				
O Dose 1 – Date re	eceived] / [/																	
O Dose 2 – Date re	eceived] / [/																	
What brand of vaccine	-			6			_				1	1			1		1	1				1
O Pfizer-BioNTech () Oxford	d-AstraZ	eneca	0	Mode	erna	C) OI	her													

ľ	lealth Questionnaire (continued)		
	Are you pregnant?*	O Yes	O No
	Have you received any other vaccination in the last 7 days?	() Yes	O No
	Have you had an allergic reaction to a previous dose of a COVID-19 vaccine?	() Yes	O No
	Have you had any other serious adverse reaction to a previous dose of COVID-19 vaccine?	() Yes	O No
	Have you ever had anaphylaxis to another vaccine or medication?	O Yes	O No
	Have you ever had mastocytosis (a mast cell disorder) which has caused recurrent anaphylaxis?	O Yes	O No
	Do you have a bleeding disorder or are you currently taking any medicine to thin your blood (an anticoagulant therapy)?	() Yes	O No
	Do you have a weakened immune system (immunocompromised)?	O Yes	O No
	Have you had COVID-19 infection before?	O Yes	O No
	Have you been sick recently with a cough, sore throat, fever or are feeling sick in another way?	() Yes	O No
	Relevant for AstraZeneca COVID-19 vaccine only		
	Are you under 60 years of age?*	O Yes	O No
	Have you ever had cerebral venous sinus thrombosis (a type of brain clot)?*	O Yes	O No
	Have you ever had heparin-induced thrombocytopenia (a rare reaction to heparin treatment)?*	O Yes	O No
	Have you ever had blood clots in the abdominal veins (splanchnic veins)?*	O Yes	O No
	Have you ever had antiphospholipid syndrome associated with blood clots?*	O Yes	O No
	Have you had capillary leak syndrome in the past?*	() Yes	O No
	Have you had thrombosis (clotting) with thrombocytopenia (low platelets) syndrome after having a previous dose of AstraZeneca?*	() Yes	O No
	*Pfizer or Moderna are the preferred vaccines for people in these groups.		
	Relevant for Pfizer or Moderna COVID-19 vaccine only		
	Have you been diagnosed with myocarditis and/or pericarditis that is attributed to a previous dose of Pfizer or Moderna?	() Yes	O No
	Have you had myocarditis, pericarditis or endocarditis within the past six months?	() Yes	O No
	Do you currently have acute rheumatic fever or acute rheumatic heart disease?	O Yes	O No
	Do you have severe heart failure?	O Yes	O No

If you answered Yes to any of the above questions, you may still be able to receive Pfizer or Moderna, however you should talk to your GP, immunisation specialist or cardiologist first to discuss the best timing of vaccination and whether any additional precautions are needed.

Consent to receive COVID-19 vaccine

I confirm I have received and understood information provided to me on COVID-19	vaccinatio	n
I agree to receive a course of COVID-19 vaccine (two doses of the same vaccine)?	O Yes	O No
I give my permission for WA Health to contact me by email, telephone or SMS to monitor vaccine safety and effectiveness	O Yes	O No
I confirm that none of the conditions above apply. or I have discussed these		

and/or any other special circumstances with my regular health care provider and/or vaccination service provider

Legal guardian or legal substitute decision-maker details

I am the patient's legal guardian or legal substitute decision-maker, and agree to COVID-19 vaccination of the patient named above

First name																				
Last name												4	-f							
Date		/		/						c	lecis	ion-r	nake	egai er	guai	ruar	I OF I	egai	substitu	le
Email address																				

O Yes O No

O Yes O No

Signature of person receiving vaccine

Verbal consent for va	accinatio	on was g	jiven	O Yes	O No															
Date] / [/		Time			Signature of person taking consent												
Consent person's name										•										
Contact number					Rela	tionship														
Data entry O AIR	0	webPA	s O	WINVAC		1EX														
Office use only – vaccine administration																				
Place vaccine b	atch lab	oel here		Vaccine	e serial nur	nber:														
Injection site																				
O Left arm O Right arm O Other																				
Dose number and a	dminist	ration d	ate																	
O Dose 1 – Date rec	O Dose 1 – Date received / / / O Dose 2 – Date received / / /																			
Brand of vaccine																				
O Pfizer-BioNTec	ch O	Oxford	-AstraZe	neca C	Moderna	O Ot	ner													
Signature o vaccinato																				
					s of the imn other syst		are co	rrect. I	acknov	vledg	e the int	tegrity	of thi	s data						
Name of vaccinato	r																			

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