



MERREDIN COLLEGE

A Wheatbelt Independent Public School

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 **Friday, 22 October 2021.**
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

Health Questionnaire (continued)

- Are you pregnant?* Yes No
- Have you received any other vaccination in the last 7 days? Yes No
- Have you had an allergic reaction to a previous dose of a COVID-19 vaccine? Yes No
- Have you had any other serious adverse reaction to a previous dose of COVID-19 vaccine? Yes No
- Have you ever had anaphylaxis to another vaccine or medication? Yes No
- Have you ever had mastocytosis (a mast cell disorder) which has caused recurrent anaphylaxis? Yes No
- Do you have a bleeding disorder or are you currently taking any medicine to thin your blood (an anticoagulant therapy)? Yes No
- Do you have a weakened immune system (immunocompromised)? Yes No
- Have you had COVID-19 infection before? Yes No
- Have you been sick recently with a cough, sore throat, fever or are feeling sick in another way? Yes No

Relevant for AstraZeneca COVID-19 vaccine only

- Are you under 60 years of age?* Yes No
- Have you ever had cerebral venous sinus thrombosis (a type of brain clot)?* Yes No
- Have you ever had heparin-induced thrombocytopenia (a rare reaction to heparin treatment)?* Yes No
- Have you ever had blood clots in the abdominal veins (splanchnic veins)?* Yes No
- Have you ever had antiphospholipid syndrome associated with blood clots?* Yes No
- Have you had capillary leak syndrome in the past?* Yes No
- Have you had thrombosis (clotting) with thrombocytopenia (low platelets) syndrome after having a previous dose of AstraZeneca?* Yes 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 No
- Have you had myocarditis, pericarditis or endocarditis within the past six months? Yes No
- Do you currently have acute rheumatic fever or acute rheumatic heart disease? Yes No
- Do you have severe heart failure? Yes 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 vaccination Yes No

I agree to receive a course of COVID-19 vaccine (two doses of the same vaccine)? Yes No

I give my permission for WA Health to contact me by email, telephone or SMS to monitor vaccine safety and effectiveness Yes 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 Yes No

Signature of person receiving vaccine

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

Date / /

Signature of legal guardian or legal substitute decision-maker

Signature of legal guardian or legal substitute decision-maker

Email address

Office use only – verbal consent

Verbal consent for vaccination was given Yes No

Date / /

Time

Signature of person taking consent

Consent person's name

Contact number

Relationship

Data entry AIR webPAS WINVAC MMEX

Office use only – vaccine administration

Place vaccine batch label here

Vaccine serial number:

Injection site

Left arm Right arm Other

Dose number and administration date

Dose 1 – Date received / / Dose 2 – Date received / /

Brand of vaccine

Pfizer-BioNTech Oxford-AstraZeneca Moderna Other

Signature of vaccinator

I hereby confirm that the details of the immunisation are correct. I acknowledge the integrity of this data and this may be integrated with other systems.

Name of vaccinator