Consent for Measles, Mumps and Rubella (MMR) Vaccination

NSW GOVERNMENT Health

Parent/Guardian to complete. Please print in **BLOCK** letters using a **black** or **blue** pen.

1. Student's Details

Surname

Given Name/s

Date of Birth / /

Gender ☐ M ☐ F

Grade

Medicare Number

☐ Number beside your child's name on the Medicare card

Name of School

Country of Birth

Does your child speak a language other than English at home?

☐ No. English only ☐ Yes

If yes, what languages other than English are spoken at home (specify the actual language)?

2. Indigenous Status

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

3. MMR Vaccination History

According to your child's immunisation records, how many doses of MMR Vaccine has your child previously received (please tick one box)?

☐ 0 ☐ 1 ☐ 2 ☐ Don't know

Please turn over ➔

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MMR Consent Form and Record of Vaccination

4. Consent

I have read and understood the information provided regarding the benefits and the possible side effects of the Measles, Mumps and Rubella (MMR) vaccine.

I hereby give consent for my child, named above, to receive 1 dose of MMR vaccine.

I declare, to the best of my knowledge, that my child:

1. Has not had an anaphylactic reaction following any vaccine.
2. Does not have an anaphylactic sensitivity to any of the vaccine components listed in the *Information for you and your child* in the Parent Information Kit.
3. Does not have any of the conditions listed in the parent information sheet where the vaccine should not be given.
4. Is not pregnant.

Name of Parent/Guardian (e.g. JOHN SMITH)

Home Address

Postcode

Best Contact Number (include area code e.g. 02)

Best Alternate Number (include area code e.g. 02)

Signature of Parent/Guardian

×

Date / /

OFFICE USE ONLY

Arm Left Right

Time of Vaccination (24hr) :

Vaccine Batch Number

Nurse's Signature

×

Date / /

Parent/Guardian Measles, Mumps and Rubella (MMR) Record of Vaccination

MMR Record of Vaccination

Parent/Guardian to complete

Name of Student (e.g. JANE SMITH)

OFFICE USE ONLY

Arm Left Right

Time of Vaccination (24hr) :

Vaccine Batch Number

Nurse's Signature

×

Date / /

What to do after the vaccination

- Keep this record, as you may be required to provide this information later.
- Advise your local doctor of the date of this vaccination so that your child's records are kept up to date.

What to do if a reaction occurs

- Put a cold damp cloth on the injection site to relieve tenderness.
- Take paracetamol for pain.
- Drink extra fluids.

If your child suffers a reaction that you are concerned about please contact your local doctor.

If this is your child's first dose of MMR vaccine, you should contact your doctor to arrange a second dose of free MMR vaccine in 4 weeks time

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