FNQ COVID-19
School Vaccination Program

The Pharmacy Guild of Australia

Consent and Information Form

The purpose of collecting your details and that of your child, via this form, is to gain consent for your child to receive two (2) doses of the coronavirus vaccine (Moderna/Spikevax).

CHILD'S DETAILS

School name:
(please write clearly)

Class/Year:

First Name

Last Name:

Date of birth: ____ / ____ / ____
dd/mm/yyyy

Gender: ☐ Male ☐ Female ☐ Unspecified

Is your child of Aboriginal or Torres Strait Islander origin?
(please tick)
☐ Aboriginal Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander
☐ Neither Aboriginal or Torres Strait Islander ☐ Prefer not to say

Contact number: **Email address:**

Address:

Suburb:

State: **Postcode:**

Does your child have a Medicare Card? (please tick) ☐ Yes ☐ No

If yes, please provide the Medicare Number for the child: ☐☐☐☐☐☐☐☐☐☐ | ☐

(10 digit Medicare Card Number + Individual Reference Number (IRN))

Is an interpreter required for your child? ☐ Yes ☐ No

PARENT, LEGAL GUARDIAN/AUTHORISED PERSON DETAILS

First Name:

Last Name:

Mobile: **Email address:**

Relationship to child: ☐ Parent ☐ Legal guardian ☐ Authorised person

Is your address the same as your child? ☐ Yes ☐ No (if No, please record your address below)

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PRE-VACCINATION CHECKLIST

Please indicate if the student:

- ☐ has a disease that lowers immunity (e.g. leukaemia, cancer, HIV/AIDs) or is having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy)
- ☐ has a chronic illness
- ☐ has had a severe reaction following any vaccine
- ☐ has a bleeding disorder
- ☐ has any severe allergies (to anything)
- ☐ does not have a functioning spleen
- ☐ has had any vaccine in the past month
- ☐ lives with someone who has a disease that lowers immunity (e.g. leukaemia, cancer, HIV/AIDs), or lives with someone who is having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy)
- ☐ has had an injection of immunoglobulin, or received any blood products or a whole blood transfusion within the past year
- ☐ faints when given an injection
- ☐ is pregnant
- ☐ none of the above

COVID-19 PRE-VACCINATION CHECKLIST

Please indicate if the student:

- ☐ has had an allergic reaction to a previous dose of a COVID-19 vaccine
- ☐ takes any medicine to thin their blood (an anticoagulant therapy)
- ☐ has had a serious adverse event, that following expert review was attributed to a previous dose of a COVID-19 vaccine
- ☐ has had a COVID-19 vaccination before
- ☐ has ever had mastocytosis which has caused recurrent anaphylaxis
- ☐ has had COVID-19 before
- ☐ none of the above

CONSENT STATEMENT

- I have read and understand current information on the vaccines provided by the Commonwealth Department of Health (online: www.australia.gov.au/covid19vaccines) which includes details regarding all real and potential side effects associated with having the COVID-19 vaccination.
- I am aware I can discuss the benefits and risks of having the COVID-19 vaccination by telephoning 134 COVID (13 42 68) or discuss with my doctor or vaccination centre health professional.
- I understand that consent can be withdrawn at any time before vaccination.
- I am aware I can discuss the benefits and risks of having the COVID-19 vaccination by telephoning 134 COVID (13 42 68) or discuss with my pharmacist or vaccination centre health professional.
- I am not aware of any legal or other reason that prevents me from providing unrestricted consent for this young person for this treatment.

☐ **On the basis of the above consent statement, yes, I consent for my child named in this form to receive the recommended doses of the COVID-19 Moderna Elasomeran vaccine:**

(a) at their School (identified above); and

(b) from a registered pharmacist who is authorised in the State or Territory where the School is located to administer COVID-19 vaccine.

Name:	Signature:	Date:
_____	_____	____ / ____ / ____

Privacy Collection Statement

By submitting this form, I acknowledge that the School named in this form is collecting personal information about the child and the Parent/Guardian (your personal information) to arrange, where the Parent/Guardian has provided informed consent, for the administration to the Student of the COVID-19 Moderna Elasomeran vaccine at the School by a registered pharmacist who is authorised in the State or Territory where the School is located to administer COVID-19 vaccine. By completing the form and providing informed consent your personal information is collected by the Pharmacy Guild of Australia Queensland Branch (the Guild) and provided by the Guild to:

(a) the Participating Pharmacy and its qualified pharmacists and personnel so that they can make arrangements for, and attend to, the vaccination of the Student at the School, and to keep a record of the vaccination in the Participating Pharmacy's third-party technology platform; and

(b) the School so that it can assist the Participating Pharmacy's qualified pharmacists and personnel to vaccinate the Student at the School.

The Participating Pharmacy will provide the Guild with information about the vaccination status of the Student so that the Guild can report to the School.

The Guild and the Participating Pharmacy will use their service providers to assist in the collection, retention and maintenance of the Parent/Guardian and Student personal information, and the provision of reports to the School.

Your personal information will not be used for any other purpose or disclosed to any other person without your consent unless doing so is authorised or required by law.

If you do not provide your personal information it may not be possible to arrange for the Student to be vaccinated at the School.