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School-based Immunisation Program 2026

The School-based Immunisation Program provides routine and recommended vaccines to WA high school students for free. Students are eligible to receive the following vaccines:

Year 7: Diphtheria-tetanus-pertussis (dTpa) and human papillomavirus (HPV)

Year 10: Meningococcal ACWY (MenACWY)

Please read, sign and return this form to your child's school.

Important: Only a parent or legal guardian is authorised to give consent or decline vaccination for a child. If you are **not** the child's parent or legal guardian, **do not complete this form.**

Additional needs required: people who speak limited or no English, or who are Deaf or hard of hearing, have the right to request access to language services when using WA Health services. This includes interpreting services, Auslan and translated health information.

Interpreter required: Yes No If yes, which language is required

If you need help completing this form, please email SBIP@health.wa.gov.au or call 9222 2486.

Child details

Please fill in this section whether you consent to your child receiving vaccines or not.

Child's last name

Child's first name

The individual only has a single name

Date of birth / /

Gender Male Female Undisclosed

Residential address

Suburb

Postcode

Medicare number

Reference number
next to child's name

Medicare card
not available/shown

School
year group

Name of the school your child attends

Does the child identify as Aboriginal and/or
Torres Strait Islander descent?

Aboriginal Torres Strait Islander Both

Prefer not to say Neither

Mobile phone

Child does not have a mobile phone

Landline phone

Parent/legal guardian details

Please fill in this section whether you consent to your child receiving vaccines or not.

Do you have a VaccinateWA account? Yes No Unsure (if no, one will be created for you and your child)

Parent/legal guardian last name

Parent/legal guardian first name

The individual only has a single name

Parent/legal guardian details (continued)

Do you identify as Aboriginal and/or Torres Strait Islander descent?

Aboriginal Torres Strait Islander Both Prefer not to say Neither

Parent/guardian gender

Male Female Undisclosed

Parent/guardian date of birth

/ /

Mobile phone (preferred)

Landline phone

Email

Residential address (if different to child's address)

Suburb

Postcode

Medicare number

Reference number

Medicare card
not available/shown

Consent section – parent/guardian to complete

Has the person being vaccinated ever had a serious reaction to any vaccine?

Yes No

Does the person being vaccinated have any severe allergies?

Yes No

Does the person being vaccinated have any long term medical conditions
(For example, diabetes, epilepsy)?

Yes No

Has the person being vaccinated fainted when receiving an injection?

Yes No

Does the person being vaccinated have a disease that lowers their immunity or
is receiving treatment that lowers their immunity?

Yes No

If you have answered Yes to any of the above questions, please provide additional information:

- I am the parent/guardian and am authorised to give consent or non-consent for my child to be vaccinated. I have read and understand the information provided about vaccination, including the possible vaccine side effects. I understand I can discuss the risks and benefits of vaccination with my GP, call the school immunisation nurse, or contact the school immunisation team. Consent provided for the above-mentioned vaccine(s) will remain valid until 31 December 2027, and can be withdrawn by contacting the school team. For contact details, please visit [healthysa.gov.au/adolescentimmunisation](https://www.healthysa.gov.au/adolescentimmunisation)
- I understand the information provided on this form will be recorded on relevant State and Commonwealth immunisation registers. It will remain confidential and will be used to monitor immunisation rates and inform program improvement.

• Do you give permission for WA Health to contact you by SMS to monitor vaccine safety and effectiveness? Yes No

Please ensure you tick and sign the green boxes for your child to be vaccinated.
If you do not want your child to receive a specific vaccine, tick and sign the relevant red box.

Year 7

Diphtheria, tetanus and whooping cough (1 dose of adolescent booster dTpa vaccine)

Yes Signature: _____ Date: ____ / ____ / ____

No Signature: _____ Date: ____ / ____ / ____

Human papillomavirus (1 dose of HPV vaccine)

Yes Signature: _____ Date: ____ / ____ / ____

No Signature: _____ Date: ____ / ____ / ____

Year 10

Meningococcal ACWY (1 dose of menACWY vaccine)

Yes Signature: _____ Date: ____ / ____ / ____

No Signature: _____ Date: ____ / ____ / ____

For office use only

Immunisation provider comments

Vaccine	Consent		Date given	Batch	Vaccinator	Site: Left arm	Site: Right arm	Record entered in AIR
	Yes	No						
HPV								
dTpa								
MenACWY								
Other (specify)								

Has AIR been checked before vaccination? Yes No

Notes (i.e. date AIR checked):

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Telephone consent

Verbal consent for vaccination was given Yes No

Time : : Date / /

Signature

Signature

Name

Name

Consent provided by (name)

Relationship to child (e.g. mother, father, guardian)

Contact phone

Data entry
 VaccinateWA AIR webPAS CHIS WINVAC MMEX

Comments