Consent Form For Children

Version 4.0

This form should be used to record the administration of MVA-BN (mpox) vaccine for children aged less than 16 years

Complete the form in block capitals using a pen
Please complete the details in Parts 1 and 2 and then give the form back to your vaccinator.

Part 1: Personal Details

Complete this part for the person getting vaccinated (Please use block capitals)

Forename:

Middle Name:

Surname (Family Name):

Otherwise known as:

Personal Public Service Number (PPSN)*:

**This field is not mandatory, the vaccine can be given if PPSN is not provided.*

Date of Birth: D D M M Y Y Y Y

Sex at Birth: Male Female

Mother's Surname at Birth:

Address:

County:

Eircode:

Ethnic or Cultural Background:

A. White

A.1 Irish

A.2 Irish Traveller

A.3 Roma

A.4 Any other White background

B. Black or Black Irish

B.1 African

B.2 Any other Black background

C. Asian or Asian Irish

C.1 Chinese

C.2 Indian/Pakistani/Bangladeshi

C.3 Any other Asian background

D. Other, including mixed background

D.1 Arab

D.2 Mixed, write in description

Description

D.3 Other, write in description

Description

E. Prefer not to say

Country of Birth:

Mobile Phone Number:

Email Address:

GP Name and Address:

Please answer the following questions

1. Has this child ever received an MVA-BN (mpox) vaccine? Yes No

   If yes, what was the name of the vaccine?

   If yes, how many doses of the MVA-BN (mpox) vaccine did this child receive?

   One Dose Two Doses Unknown

   If yes, what date/s did this child receive the MVA-BN (mpox) vaccine? Dose 1 D D M M Y Y Y Y

   Dose 2 D D M M Y Y Y Y

2. Has this child had any allergies to any vaccines in the past? Yes No
3. Has this child had any allergies to eggs or egg products (including chicken or feathers) in the past? Yes No
4. Do they have any serious allergies (including Trometamol or antibiotics)? Yes No

   If yes, please specify
5. Do they currently have a raised temperature or feel unwell? Yes No
6. Do they have atopic dermatitis? Yes No
7. Do they have a condition or are they receiving treatment that weakens their immune system? Yes No
8. Do you plan to get your child vaccinated with a COVID-19 vaccine in the next 4 weeks? Yes No
9. Has your child received an MMR, varicella or yellow fever vaccine in the last 4 weeks? Yes No
10. Do you plan to get your child vaccinated with an MMR, varicella or yellow fever vaccine in the next 4 weeks? Yes No
11. Is the person getting vaccinated pregnant or breastfeeding? Yes No

Please Note: *The MVA-BN (mpox) vaccine may be given to those who are pregnant or breastfeeding after a risk benefit discussion with a healthcare professional. Please speak to your vaccinator if you have any questions about this.*

Part 2: Consent

Please Note: *If you are receiving an MVA-BN (mpox) vaccine called Imvanex, this is licensed by regulators for use in persons aged 12 years and older. If you are receiving an MVA-BN (mpox) vaccine called Jynneos, this is licensed by regulators for use in persons aged 18 years and older. Administration in younger people may be considered following an individual benefit-risk assessment.*

Please tick the relevant boxes and sign to give consent for this child to be vaccinated with a primary course of MVA-BN (mpox) vaccine OR to receive a MVA-BN (mpox) booster vaccine.

I have been made aware of possible risks and benefits of these vaccines. ☐

I consent for this child to receive a course of MVA-BN (mpox) vaccine (1 or 2 doses 28 days apart) as determined by a suitable healthcare professional. ☐

OR

I consent for this child to receive an MVA-BN (mpox) booster vaccine (1 dose) as determined by a suitable healthcare professional. ☐

Name *(please print)*:

(please tick): Parent ☐ Legal Guardian ☐

Signature: Date: D D M M Y Y Y Y

Privacy Notice: The HSE do not use consent as a lawful basis for processing personal data. In the interest of transparency, to explain how we collect and use personal information the HSE provides details within the HSE Privacy Notice for Patients and Service Users which is accessible via the HSE Privacy Statement. The processing of your child's data will be lawful and fair. It will only be processed for specific purposes including, to manage the vaccinations, to report and monitor vaccination programmes, to validate clients and provide health care. Data sharing between HSE departments may also occur.

For Office Use Only

Administration Details:

Dose No.	Date Given (DD/MM/YYYY)	Vaccine Name & Manufacturer	Batch Number	Expiry Date (DD/MM/YYYY)	Use by Date (DD/MM/YYYY)	Injection Site	Injection Route
1	D D M M Y Y Y Y			D D M M Y Y Y Y	D D M M Y Y Y Y		
2	D D M M Y Y Y Y			D D M M Y Y Y Y	D D M M Y Y Y Y		
Booster dose	D D M M Y Y Y Y			D D M M Y Y Y Y	D D M M Y Y Y Y		

Prescriber Signature:

PIN/MCRN:

Vaccinator Signature:

PIN/MCRN:

HSE Clinic/Hospital Name, Address, or Stamp: