



Consent Form for Children

This form should be used to record the administration of MVA-BN vaccine

Version 3.0 5 August 2022

Privacy Statement: HSE staff are aware of their obligation under the Data Protection Acts, 1988-2018 (including GDPR). The information provided will be included in an Immunisation Database. The HSE will use this information to validate clients, monitor vaccination programmes and provide health care.

Section 1: Personal Details

Complete this part for the person getting vaccinated (PLEASE USE BLOCK CAPITALS)

First name: Surname (Family Name):

Personal Public Service Number (PPSN):

Date of Birth: Gender (please circle): Male Female

Address:

County: Eircode:

Parent/Legal Guardian first name and surname:

Mobile Phone Number: Email Address:

GP Name and Address:

Please answer the following questions (Circle your answer)

Has this child ever received MVA-BN or another smallpox vaccine? Yes No

If yes, what was the name of the vaccine?

What date did they receive it?

Has this child had any allergies to any vaccines in the past? Yes No

Has this child had any allergies to eggs or egg products (including chicken or feathers) in the past? Yes No

Do they have any serious allergies? Yes No

If yes, please specify

Do they currently have a raised temperature or feel unwell? Yes No

Do they have atopic dermatitis? Yes No

Do they have a condition or are you receiving treatment that weakens your immune system? Yes No

Is the person getting vaccinated pregnant or breastfeeding? Yes No

Do you plan to get your child vaccinated with a COVID-19 vaccine in the next 4 weeks? Yes No

Section 2: Consent

Please tick the box for each statement and sign to give consent to be vaccinated

I understand the MVA-BN vaccine is licensed by regulators for use in persons aged 18 and over.

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

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

I confirm by signing this form that I am authorised to give consent on behalf of the above named child

Signature: Date:

(please circle) Parent Legal Guardian

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Date Given (DD/MM/YYYY)	Vaccine Name & Manufacturer	Batch Number	Expiry Date Month/Year	Use by date	Injection Site

Prescriber Signature: HSE Clinic / Hospital Name, Address, or Stamp

PIN/MCRN:

Vaccinator Signature:

PIN/MCRN: