RESTRICTED

Youth Preventive Services Division
Health Promotion Board
Tel: 6435 3940 / 6435 3537 Fax: 6438 7166

CONSENT FORM FOR IMMUNISATION

Student's Name: (IN FULL)	**Gender: Male /Female**	**Date of Birth:**	**NRIC / B.C. / FIN:**
School:		**Class:**	

Dear Parent/Guardian
Please complete and sign (in ink) the Consent Form and submit it togeter with all immunisation records and other relevant documents to the class teacher. This Form is valid for one year. This Form may take you 5 to 10 minutes to complete.
Note: Immunisations against diphtheria and measles are compulsory by law in Singapore.

DIRECTOR
YOUTH PREVENTIVE SERVICES DIVISION

Please tick ☑ in the box where applicable.

1. Is your child/ward allergic to any of the following?

- Drugs/Medicines ☐ No ☐ Yes If yes, specify _____
- Immunisations ☐ No ☐ Yes If yes, specify _____
- Food ☐ No ☐ Yes If yes, specify _____
- Others ☐ No ☐ Yes If yes, specify _____

2. Has your child/ward received any immunisation in the last 2 years?

☐ No ☐ Yes If yes, specify _____
(type and date of immunisation)

3. Has your child/ward had any illness recently or does your child have a long term medical condition?

☐ No ☐ Yes If yes, specify _____

4. Is your child/ward taking any medicine currently?

☐ No ☐ Yes If yes, specify _____

P.T.O.

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☐ **YES,** I consent to let my child / ward receive immunisations for diphtheria, tetanus and pertussis (Tdap) immunisations and polio (Oral Sabin) from the School Health Service. I understand that the measles, mumps and rubella (MMR) immunisations will only be given if my child has missed earlier dose(s).

As my child is left handed, please give the injection in the right arm.

☐ **NO,** I wish to take my child / ward to my family doctor for immunisation.

I confirm that the information provided in this Form is true to the best of my knowledge.

Name of *Father/Mother/Guardian: _____

Contact Number: (H) _____ (O) _____

(HP) _____

Email Address: _____

Father's/Mother's/Guardian's* NRIC No.: _____

Signature of *Father/Mother/Guardian: _____ Date: _____

*(*Please delete accordingly)*

For official use:

Immunisation Type	**Dose Sequence**	**Signature / Date**	
		Screener	**Vaccinator**
Measles, Mumps & Rubella			
Oral Sabin			
Diphtheria / Tetanus / Pertussis			