

# CONFIDENTIAL

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

School Health Service conducts age-appropriate health screening for students in schools. Please refer to pages six to nine for the full list of health screening services that will be conducted by the School Health Service.

School Health Service also administers immunisation against diseases to students, in accordance with the Singapore National Childhood Immunisation Schedule. Primary 1 students will be given immunisations against measles, mumps and rubella. Polio, diphtheria, tetanus and pertussis immunisations will be given when required (for example, student has missed pre-school dose(s)).

Note: Immunisation against diphtheria and measles are compulsory by law in Singapore.

Please complete and sign the Form below (in ink) and submit it together with all immunisation records and other relevant documents to the class teacher. This Consent Form is valid for one year.

DIRECTOR  
YOUTH PREVENTIVE SERVICES DIVISION

Please tick  in the box where applicable.

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

No     Yes    If yes, specify \_\_\_\_\_  
(type and date of immunisation)

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

No     Yes    If yes, specify \_\_\_\_\_

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

No     Yes    If yes, specify \_\_\_\_\_

P.T.O.

CONFIDENTIAL

YES, I consent to let my child / ward receive immunisations for measles, mumps and rubella (MMR) from the School Health Service. I understand that the diphtheria, tetanus and pertussis (Tdap) immunisations and/or polio (Oral Sabin) 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\*

\_\_\_\_\_  
Signature of Father / Mother / Guardian\*

\_\_\_\_\_  
Father's / Mother's / Guardian's\* NRIC No.

\_\_\_\_\_  
Date

(\*Please delete accordingly)

For official use:

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