

## COVID-19 VACCINATION DRIVE AT SCHOOLS CONSENT FORM FOR ALL SCHOOL LEARNERS

Dear Parent/Guardian/Caregiver

The Department of Basic Education, in partnership with the Department of Health, has agreed to provide in-school vaccinations against COVID-19 for all learners of 12 years and older, as well as, educators and school support staff at all primary and secondary public schools.

The Western Cape Department of Health and Wellness has contacted your child's school in preparation for such a visit.

For your child to receive these services we need you to give permission by completing the consent form on the back of this page. Please also find a pamphlet with frequently asked questions and answers attached for information on the COVID-19 vaccine and process.

Please indicate your consent for the following, which could also be performed:

1. Checking your child's health – blood pressure, temperature and observation for 15 minutes for any adverse side effects following the vaccination.
2. Health education on COVID-19 and the vaccines.
3. Comprehensive briefing on the process to follow should the learner be concerned about his/her health in the weeks following the vaccination.

Please contact the principal for any enquiries or additional information about these services or if you have given written permission and you would like to withdraw.

The school will communicate the scheduled date for the administration of COVID-19 vaccines to you.

**Please return the completed consent form to the school tomorrow.**

Kind regards

**Western Cape Department of Health and Wellness**



CONSENT FORM: COVID-19 VACCINATION SERVICES

Parents/guardians/caregivers please COMPLETE the following:

Name of learner: .....

ID or CEMIS no.: .....

School name: .....

Education district: .....

A. PLEASE COMPLETE THE FOLLOWING:

I ..... give permission for my child to receive the following:
(name of parent/guardian/caregiver)

Table with 2 columns: YES, NO. Rows: Vaccination (COVID-19 for children 12 years and older), Health check (mainly body temperature check and referral to a clinic, if needed), Education and counselling (COVID-19 protecting themselves and vaccination/vaccines)

PLEASE ANSWER THE FOLLOWING BY MAKING A CROSS IN THE RELEVANT BOX

Table with 4 columns: Question, YES, NO, DON'T KNOW. Rows: Is your child receiving treatment for a health problem?, Do you currently have a household member with COVID-19?, Does your child have any allergies?, If yes, what is your child allergic to?

B. SIGNATURE

Signature: parent/guardian/caregiver, Signature: child, 12 years and older, Full name(s): parent/guardian/caregiver, Full name(s): child, 12 years and older, Contact number: parent/guardian/caregiver, Contact number: child, 12 years and older, Date, Date

