Government of **Western Australia**
Department of **Health**

Respiratory Syncytial Virus (RSV) Infant Immunisation Consent Form

Affix unique patient identification label in this box

Please print clearly in capital letters using a blue or black ball point pen.

Infant's details

First name (if known) ....

Note: Where the baby has not been named, use the term '**Baby of**' as the first name. For a multiple birth, use '**Baby 1 of**', '**Baby 2 of**'.

Last name (use mother's surname) ....

Date of birth (DD/MM/YYYY) ..../............./...................

Sex: Male ◯   Female ◯   Indeterminate ◯   Medicare number (if known) ....

Parent or guardian's details

Person providing consent (select one): Mother ◯   Father ◯   Other (specify) ....

First name ....   Last name ....

Telephone number (mobile preferred) ....

Mother's address: same address as the mother's Medicare records.

....

....   Postcode ....

Mother's address is required to record infant's immunisation in the Australian Immunisation Register.

Consent to administer Beyfortus® (nirsevimab)

▸ I have read and understood the information contained in the
2025 RSV Infant and Maternal Immunisation program – What parents and carers need to know
information sheet regarding the potential benefits and risks of Beyfortus.   Yes ◯   No ◯

▸ I have had an opportunity to have my questions answered.   Yes ◯   No ◯

▸ I acknowledge that my child's Beyfortus immunisation will be recorded on the
Australian Immunisation Register.   Yes ◯   No ◯

▸ I consent to my infant/child receiving the Beyfortus immunisation.   Yes ◯   No ◯

Signature of parent/guardian ....   Date: ..../............./...................

Dose administered (select one)

◯ **Infant weighing less than 5 kg → 0.5 mL** (batch number ....)

◯ **Infant weighing 5 kg or more → 1.0 mL** (batch number ....)

◯ **Medically at-risk child born on or after 1 October 2023 → 2 x 1.0 mL** (batch number ....)

Site Beyfortus administered: left anterolateral thigh ◯   right anterolateral thigh ◯

Date Beyfortus administered ..../............./...................   Name of hospital or immunisation clinic ....

Name of person administering Beyfortus ....

Signature and designation (e.g. RN or RM) of person administering Beyfortus ....