

Diphtheria/Tetanus/Polio and Meningitis ACWY immunisations

PARENT / GUARDIAN: Please complete ALL sections on this page.

Child's full name: (first name and surname)		Date of Birth:
Home address:		Emergency contact phone number for parent / guardian:
Postcode:		
Email:		Gender of child (<i>please circle</i>): Male Female
NHS Number (<i>if known</i>):		Ethnicity of child:
GP name and address:		GP telephone number:
School:		Year Group/Class:

CONSENT FOR IMMUNISATION

Please complete **BOTH** boxes

If your child has already had the vaccine/s or you wish to refuse, please fill in the 'Refusal' box only

The person with parental responsibility must sign this form – for more information, go to:

<https://www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility>

Please note: young people under the age of 16 can give or refuse consent if considered competent to do so by nursing staff.

<p>I have read and understood the leaflet supplied and I consent to my child receiving the following vaccine:</p> <p style="text-align: center;">Diphtheria/Tetanus/Polio booster immunisation:</p> <p>Parent / Guardian name:.....</p> <p>Signature:.....</p> <p>Relationship to child:.....</p> <p>Date:.....</p>	<p>I have read and understood the leaflet supplied and I consent to my child receiving the following vaccine:</p> <p style="text-align: center;">Meningococcal ACWY immunisation:</p> <p>Parent / Guardian name:.....</p> <p>Signature:.....</p> <p>Relationship to child:.....</p> <p>Date:.....</p>
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REFUSAL OF CONSENT:	
<input type="checkbox"/> I DO NOT want my child to receive the DTP vaccine	Name of Parent/ Guardian:
<input type="checkbox"/> I DO NOT want my child to receive the Meningitis ACWY vaccine	Signature:

Please also answer the questions below – if you answer YES to any questions, please give details:

1.	Has your child received a dose of Meningococcal ACWY since the age of 10? If YES , please give date:	YES / NO
2.	Has your child had a Diphtheria/Tetanus/Polio immunisation in the last 5 years? If YES , please give date of immunisation:	YES / NO
3.	Does your child have any allergies? If YES , please give details:	YES / NO
4.	Has your child had a confirmed reaction to a vaccine that required hospital treatment? If YES , please state which vaccine:	YES / NO
5.	Does your child have any medical conditions, especially a bleeding disorder? If YES , please give details:	YES / NO
6.	Is your child taking any medication? If YES , please give name of medication:	YES / NO
7.	Has your child had 2 doses of the MMR vaccine?	YES / NO

FOR OFFICE USE ONLY

IMMUNISATION NURSE TO COMPLETE THIS SECTION

1.	Is the young person fit and well for vaccination today?	YES / NO
2.	Since this form was completed, has the young person had any other vaccinations, or any change to their medical history?	YES / NO
3.	Is there any possibility of pregnancy?	YES / NO
4.	Is this vaccine being given with self-consent? If yes, please complete Gillick Competency Assessment form	YES / NO

DTP VACCINATION	
Manufacturer: (Circle or delete)	Revaxis
Batch/Expiry:	
Date/time given:	
Site: (Circle or delete)	L) deltoid / R) deltoid
Route: (Circle or delete)	IM / SC
Given by:	Name of nurse: Signature:

MEN ACWY VACCINATION	
Manufacturer:	Nimenrix / Menveo
Batch/Expiry:	
Date/time given:	
Site: (Circle or delete)	L) deltoid / R) deltoid
Route: (Circle or delete)	IM / SC
Given by:	Name of nurse: Signature:

Additional comments: