

Meningococcal ACWY / Diphtheria, Tetanus and Polio Immunisation Consent Form

Parent/guardian to complete

As part of the scheduled 5-19 Healthy Child immunisation programme a team of School Nurses will be visiting schools in the next few months. They will be immunising young people against MenACWY and DTP who have returned signed consent forms. Please note that these will be two separate injections given on the same day.

Important Information: Ensure that you and your child have read the accompanying leaflet before completing the form. If you have any queries please contact the Childhood Immunisation Team.

Please return the form to school as soon as possible.

Pupil details	
Surname:	First Name:
Date of birth:	GP Practice:
Gender:	NHS Number (if known)
School	Year group
Home address:	Contact phone numbers:
Please answer the following questions	
Has your child had a severe local reaction to an immunisation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have any allergies? If so please give details below.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Additional parent/guardian comments regarding medical concerns:	
Consent	
I consent to my son/daughter receiving: <i>(please tick YES or NO)</i>	
Meningitis ACWY vaccine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Low dose diphtheria, tetanus and inactivated polio vaccine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Name and signature of parent/guardian: <i>(with parental responsibility):</i>	Date:

School Nurse use only		
Men ACWY SystemOne check (date/initials):	DTP SystemOne check (date/initials):	MMR SystemOne check (date/initials):

School nurse use only

Eligibility assessment on day of vaccination.
These questions must be asked of every child and their responses noted (last question for females only)

1. Have you had any vaccinations in the last 3 weeks? If yes, which? Yes No
2. Have you had any illnesses today or a temperature over 38°C? Yes No
3. Do you take tablets or medicines on a regular basis? If yes which? Yes No
4. Have you had a severe local reaction to a previous immunisation? Yes No
5. Do you have any allergies? Yes No
6. Are you or is there any reason for you to think you might be pregnant? Yes No

Comments:

Vaccine details

Men ACWY

Date:	Time:	Batch Number:	Expiry date:	Site/Route:
Administered by:			SystemOne:	
Comments:				

DTP:

Date:	Time:	Batch Number:	Expiry Date:	Site/Route:
Administered by:			SystemOne:	
Comments				