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| 0106  School Immunisation Team Consent Form  **Measles, Mumps & Rubella Vaccination** |

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| **1** | Child’s Surname *(and any previous Surname*) | Child’s Forename(s) | Date of Birth: | |
| Male 🞏 | Female 🞏 |

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| --- | --- | --- |
| **2** | Address & Postcode *(please write previous address overleaf if less than 3 years)* | Mobile phone number of parent/guardian |
| Email of parent/guardian |
| Ethnicity |
| GP Surgery: | NHS Number |
| School Name | Year Group |

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| **3** | **Would you like your child to receive the MMR vaccination course as necessary (please tick in the boxes below)?** | | | |
|  | **YES, I CONSENT**  Complete sections 4 & 5 and return form to school |  | **NO, I DO NOT CONSENT**  Return form to school |

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| **4** | **Important medical information – if unsure, please check with your GP** | | | |
| **Allergies:** | Has your child ever had a severe allergic reaction to any previous vaccines or medication? | Yes  🞏 | No  🞏 |
| **Medical Information:** | Does your child have any long-standing medical conditions that affect the immune system? | Yes  🞏 | No  🞏 |
| Does your child take any prescribed medication? | Yes  🞏 | No  🞏 |
| If you answered yes to any of the above, please give details: | | | |

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| **5** | Full name of parent/guardian (with parental responsibility) | Signature: |
| Relationship to child | Date |

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| **OFFICE USE ONLY** | | | | | | | | | |
| **Has the parent consented (in 3) and signed (in 5)?** | | | | | | | | | **Yes** |
|  | | **Date:** | | **Time:** | **Site of IM injection** | | **Batch number & Expiry date:** | **Immuniser:** | **Location:** |
| 1. Priorix/MMRVaxPro, 0.5ml, IM, as per PGD | |  | |  | **L** | **R** |  |  |  |
| 1. Priorix/MMRVaxPro, 0.5ml, IM, as per PGD | |  | |  | **L** | **R** |  |  |  |
| Nurses’ Checklist: | | | Nurses’ Comments: | | | | | | |
| Allergies |  | |
| Medication |  | |
| Recent vaccines |  | |
| Febrile Illness |  | |
| Pregnancy |  | |