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| **School Immunisation Team Consent Form****Meningitis ACWY and Tetanus, Diphtheria & Polio Vaccination Vaccination**  |
| Child’s Surname*(and any previous Surname):* | Child’s Forename(s): | Date of Birth: |
| Gender: Male Female |
| Address & Postcode: *(please write previous address overleaf if less than 3 years)* : | Phone number of parent/guardian: |
| Email of parent/guardian: |
| GP Surgery: Name & Address: | NHS Number: |
| School Name: | Class/Form: |
| **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? | **Yes\* No**  |
| **Meningitis ACWY:** | Has your child received a dose of **Meningitis ACWY** vaccine since the age of ten years? (If yes, a further dose may **NOT** be necessary) | **Yes\* No**  |
| **Tetanus, Diphtheria & Polio:** | Did your child receive the three doses of Tetanus, Diphtheria and Polio as a baby and a pre-school booster? | **Yes No**  |
| Has your child received a dose of Tetanus, Diphtheria and Polio vaccine in the last five years? (If yes, a further dose may **NOT** be necessary) | **Yes\* No**  |
| \* If you answered yes to any of the above, please give details, including dates : |
| **Consent for my child to receive the Meningitis ACWY vaccination** |
| ***YES, I CONSENT TO THE MENINGOCOCCAL VACCINATION*** |  |
| Signature of parent/guardian (with parental responsibility): |
| Relationship to child: | Date: |
| **Consent for my child to receive the Tetanus Diphtheria & Polio vaccination** |
| ***YES, I CONSENT TO THE TETANUS, DIPHTHERIA & POLIO VACCINATION*** |  |
| Signature of parent/guardian (with parental responsibility): |
| Relationship to child: | Date: |

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| **OFFICE USE ONLY** |
|  | Date: | Time: | Site of IM injection | Batch number & Expiry date: | Immuniser: | Location: |
| Meningococcal ACWY Conjugate as per PGD |  |  | **L** | **R** |  |  |  |
| Td/IPV as per PGD |  |  | **L** | **R** |  |  |  |
| Nurses’ Checklist: | Nurses’ Comments: |
| Allergies |  |
| Medication |  |
| Recent vaccines |  |
| Febrile Illness |  |
| Pregnancy |  |