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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 |  | |