NHS
Essex Partnership University
NHS Foundation Trust

Vaccination Consent Form

For Diphtheria, Tetanus and Inactivated Polio Vaccine (Td/IPV) and Meningitis ACWY

Child's full name (first name and surname):	Date of birth:	Male/Female:
Home Address:	Parent/Legal Guardian daytime number: Home Mobile	
NHS number (if known):	GP Surgery:	
School:	Year group/class:	

The following information is required prior to vaccination. Lack of information may result in vaccination not being given. **If you are unsure please check with your GP.** For further information about these vaccinations go to: www.nhs.uk/vaccinations **If you have any queries please contact us on 01234 310408.**

Has your child had a Diphtheria, Tetanus, Polio vaccination in the last 5 years ? **Yes** ☐ **No** ☐
If yes, please give the date: ___/___/___ (contact your GP if unsure)

Has your child had a Meningitis ACWY vaccination in the last 3 years? **Yes** ☐ **No** ☐
If yes, please give the date: ___/___/___ (contact your GP if unsure)

Has your child ever had a SEVERE reaction to any medicines including vaccines, suffers from allergies or has a condition for which they are receiving medical treatment. Please give details: **Yes** ☐ **No** ☐

Is your child on any medication? If yes please give details. **Yes** ☐ **No** ☐

Having read the information leaflet provided and/or listened to the nurse I consent to my child being vaccinated with Td/IPV and Meningitis ACWY teenage boosters.
Please ensure this consent form is signed by the parent/carer/or adult with parental responsibility

Diphtheria, Tetanus and Polio (Td/IPV) Consent Please complete either yes or no	Meningitis ACWY Consent Please complete either yes or no
YES I **WANT** my child to receive the Td/IPV vaccination Name (print)…………………………………………… Signature………………………………………… Date………………………………………………	YES I **WANT** my child to receive the Meningitis ACWY Vaccination Name (print)…………………………………………… Signature………………………………………… Date………………………………………………
NO I **DO NOT** want my child to receive the Td/IPV vaccination. Name (print)……………………… ……………… Signature………………………………………… Date……………………………………………	NO I **DO NOT** want my child to receive the Meningitis ACWY vaccination Name (print)…………………………………………… Signature………………………………………… Date………………………………………………

Every attempt will be made to contact the parent/guardian to confirm consent/non-consent. However, should no communication be received by the session date, the individual will be invited to the session to discuss their views and may be assessed (using the Fraser Competencies) to see if they are competent to make their own health decisions. If so, consent/non-consent may be taken and the vaccination given if appropriate.

Thank you for completing this form, please return it to school WITHIN ONE WEEK.

FOR OFFICE USE ONLY

Vaccination Date/Time	Site of injection (Please specify)		Batch Number Brand Expiry Date	Immuniser	Location	Leaflet given
DTP (Td/IPV) Date: ___/___/____ Time:___:___	L arm ☐	R arm ☐				☐
Men ACWY Date:___/___/____ Time:___:___	L arm ☐	R arm ☐				☐

Phone consent taken ☐	Fraser guidelines completed ☐
Name of Parent/Carer: Relationship to child: Signature of Nurse: Date:	Name of Nurse: Signature of Nurse: Date:

Date of attempted Vaccination	Reason for vaccination not given

Post immunisation issues / adverse reactions

Date	Details	Immuniser

Adverse reaction reported to MHRA / Yellow card scheme and Datix:
Name: Date: