Diphtheria/Tetanus/Polio and Meningitis ACWY (School Leaver Booster) Vaccination Consent Form

These are two separate vaccinations and consent is required for each vaccination.

School:	Year: Gender: M or F (Circle)
Child's name:	
Child's date of birth:	GP Name and Address:
Ethnicity:	
Home address: Postcode	
Name and contact telephone number of Parent/Guardian: Are you the next of kin? Y / N	

Please complete this form and return it to school. even if you do not consent to these vaccines please return the form so the School Nurses can update your child's immunisation record.

I DO consent to my child receiving: Diphtheria, Tetanus and Polio (Td/IPV) booster (tick box) ☐	**I DO NOT consent to my child receiving Diphtheria, Tetanus and Polio (Td/IPV) booster (tick box)** ☐
I DO consent to my child receiving: Meningitis ACWY vaccine (tick box) ☐	**I DO NOT consent to my child receiving Meningitis ACWY vaccine (tick box)** ☐
Signature (Person with parental responsibility/relationship):	Signature (Person with parental responsibility/relationship):
Print name:	Print name:
Date:	Date:

If you did **not** consent to your child receiving this vaccination, please give the reason. If the vaccine has already been given please record the date:

Has your child ever had a severe allergic reaction to these vaccines?
Does your child have any medical conditions, or are they currently undergoing any medical investigations?
(please provide details)

Office use only

Date and Time of Vaccination		Site of injection (please circle)		Batch number/ expiry date	Immuniser (please print)	Venue		
Td/IPV		**L** arm	**R** arm				Ant.	
Men ACWY		**L** arm	**R** arm				Post.	

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If you and your child would like to have the vaccinations:

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do they have any specific allergies?	YES ☐	NO ☐
Have they ever had a severe reaction to previous immunisations?	YES ☐	NO ☐
Are they seeing the GP or a hospital Doctor for any reason?	YES ☐	NO ☐
Are they receiving any regular treatment or medication?	YES ☐	NO ☐
Have they had any injections in the last 3 months? (*if yes when)	YES ☐	NO ☐

If you answered yes to any of the questions, please specify.

School Nurse comments:

☐ Triaged Date: Initials: