Tetanus/Diptheria/Polio and Meningitis ACWY (Teenage Booster)

VACCINATION CONSENT FORM 2017 / 2018

Sussex Community NHS
NHS Foundation Trust

The Q&A sheet that accompanies this form tells you about the vaccinations, why they are being offered and the diseases they protect against. For further information please visit www.nhs.uk (search for vaccinations)

Child's **full** legal name *(first name and surname) and preferred name if different:*		Date of Birth: Male ☐ Female ☐
Home address:		Daytime contact telephone number/mobile for parent/guardian:
Postcode	NHS Number:	Ethnicity:
School		Year group/class:
GP name and address:		

Please answer ALL of the following questions.

	YES	NO
Does your child have any allergies?		
Is your child taking any medication?		
Does your child have any medical conditions?		
If you have answered yes to any of the above or there is any other information you wish to share with us, please give details.		

Has your child had any of the vaccinations below **in the last 5 years**? **Yes** ☐ **No** ☐

If yes, please provide dates under relevant vaccine(s) below (if known)

Tetanus / Diphtheria / Polio	**Meningitis C** *(MenC)*	**Meningitis ACWY** *(MenACWY)*
Date Given:	*Date Given:*	*Date Given:*

Consent for vaccination courses *(Please complete **one** box only)*

YES I CONSENT for my child to receive the following vaccinations: 1. Tetanus/Diphtheria/Polio 2. Meningitis ACWY	**NO I DO NOT CONSENT** for my child to receive the following two vaccinations: 1. Tetanus/Diphtheria/Polio 2. Meningitis ACWY
By giving consent you agree to the following statements. I confirm I have parental responsibility for the above named child. I have read and understood the information given to me about the above vaccinations. I understand that the information provided will be shared with my GP to update my child's health record.	***Please tick reason for declining below and return form to school.*** ☐ My child has had these vaccinations in the last 5 years ☐ Do not feel that the vaccine(s) is necessary ☐ Due to a previous allergic reaction to the vaccine(s) ☐ Other *(Please state) use separate sheet if necessary*
Full Name of person with Parental Responsibility:	Full Name of person with Parental Responsibility:
Signature of person with Parental Responsibility:	Signature of person with Parental Responsibility:
Date:	Date:

Thank you for completing this form. Please detach and return to the school within one week of receipt.

Office Use - Details checked and initialled by team member | No action required …….. | Follow up by Nurse required ……..

FOR OFFICE USE ONLY

Type	Date of vaccinations	Site of injection *(please circle)*		Batch number/ expiry date	Immuniser *(please print & sign)*	Where administered *(if not school)*
Td/IPV		**L** arm	**R** arm			School
MenACWY		**L** arm	**R** arm			School

Information given as per PGD ***(Please tick)*** ☐

Name:			*Child demographics to be completed if scanning or photocoping this form.*
DOB:		**NHS No:**	

COMMUNICATION RECORD

DATE/TIME		NAME, TITLE & SIGNATURE