CONSENT FORM

Diphtheria/Tetanus/Polio and Meningitis ACWY immunisations

PARENT / GUARDIAN: Please complete ALL sections on this page.

Child's full name: (first name and surname)		Date of Birth:
Home address: Postcode:		Emergency contact phone number for parent / guardian:
Email:		Gender of child *(please circle)*: ☐ **Male** ☐ **Female**
NHS Number (*if known*):		Ethnicity of child:
GP name and address:		GP telephone number:
School:		Year Group/Class:

CONSENT FOR IMMUNISATION
Please complete BOTH boxes
If your child has already had the vaccine/s or you wish to refuse, please fill in the 'Refusal' box only
The person with parental responsibility must sign this form – for more information, go to:
https://www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility
Please note: young people under the age of 16 can give or refuse consent if considered competent to do so by nursing staff.

I have read and understood the leaflet supplied and I consent to my child receiving the following vaccine: **Diphtheria/Tetanus/Polio booster immunisation:** Parent / Guardian name:…….. Signature:…… Relationship to child:…… Date:……	I have read and understood the leaflet supplied and I consent to my child receiving the following vaccine: **Meningococcal ACWY immunisation:** Parent / Guardian name:…….. Signature:…… Relationship to child:…… Date:……

REFUSAL OF CONSENT:

☐ **I DO NOT** want my child to receive the DTP vaccine

☐ **I DO NOT** want my child to receive the Meningitis ACWY vaccine

Name of Parent/ Guardian:……

Signature……..

Please also answer the questions below – ***if you answer YES to any questions, please give details:***

1.	Has your child received a dose of Meningococcal ACWY since the age of 10? If **YES**, please give date:	☐ **YES / NO** ☐
2.	Has your child had a Diphtheria/Tetanus/Polio immunisation in the last 5 years? If **YES**, please give date of immunisation:	☐ **YES / NO** ☐
3.	Does your child have any allergies? If **YES**, please give details:	☐ **YES / NO** ☐
4.	Has your child had a confirmed reaction to a vaccine that required hospital treatment? If **YES**, please state which vaccine:	☐ **YES / NO** ☐
5.	Does your child have any medical conditions, especially a bleeding disorder? If **YES**, please give details:	☐ **YES / NO** ☐
6.	Is your child taking any medication? If **YES**, please give name of medication:	☐ **YES / NO** ☐
7.	Has your child had **2 doses** of the MMR vaccine?	☐ **YES / NO** ☐

Please email your completed form to consent.havering@nhs.net

FOR OFFICE USE ONLY

IMMUNISATION NURSE TO COMPLETE THIS SECTION

1.	Is the young person fit and well for vaccination today?	YES / NO
2.	Since this form was completed, has the young person had any other vaccinations, or any change to their medical history?	YES / NO
3.	Is there any possibility of pregnancy?	YES / NO
4.	Is this vaccine being given with self-consent? If yes, please complete Gillick Competency Assessment form	YES / NO

DTP VACCINATION	
Manufacturer: (Circle or delete)	Revaxis
Batch/Expiry:	
Date/time given:	
Site: (Circle or delete)	L) deltoid / R) deltoid
Route: (Circle or delete)	IM / SC
Given by:	**Name of nurse:** **Signature**:

MEN ACWY VACCINATION	
Manufacturer:	Nimenrix / Menveo
Batch/Expiry:	
Date/time given:	
Site: (Circle or delete)	L) deltoid / R) deltoid
Route: (Circle or delete)	IM / SC
Given by:	**Name of nurse:** **Signature**:

Additional comments: