

VACCINATION CONSENT FORM 2018 / 2019

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](http://www.nhs.uk) (search for vaccinations)

Child's <b>full</b> legal name ( <i>first name and surname</i> ) <b>and</b> name known as if different:		Date of Birth:
		Male <input type="checkbox"/> Female <input type="checkbox"/>
Home address:		Daytime <b>contact telephone number</b> /mobile for parent/guardian:
Postcode:	NHS Number:	Ethnicity:
School:		Year group/class:
GP Surgery name and address:		

Please tick either YES or NO for all of the following questions.

	YES	NO
Does the above named child have any allergies?		
Is the above named child taking any medication?		
Does the above named child have any medical conditions?		
Has the above named child had a Tetanus/Diphtheria/Polio vaccination <b>in the last 5 years</b> ? If yes, please provide the date here .....		
Has the above named child had a vaccination for Meningitis ACWY <b>since their 10<sup>th</sup> birthday</b> ? If yes, please provide the date here .....		
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.		

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

<p><b>YES I CONSENT</b></p> <p>for the above named child to receive the following vaccinations:</p> <p>1. Tetanus/Diphtheria/Polio 2. Meningitis ACWY</p> <p><b>By giving consent you agree to the following statements.</b></p> <p>I confirm I have parental responsibility for the above named child.</p> <p>I have read and understood the information given to me about the above vaccinations.</p> <p>I understand that this information will be held in the above named child's health record and also shared with their GP.</p> <p>Full Name of person with Parental Responsibility:</p> <p>Signature of person with Parental Responsibility:</p> <p>Date:</p>
---

<p><b>NO I DO NOT CONSENT</b></p> <p>for the above named child to receive the following two vaccinations:</p> <p>1. Tetanus/Diphtheria/Polio 2. Meningitis ACWY</p> <p><b>Please tick reason for declining below and return form to school.</b></p> <p><input type="checkbox"/> My child has had these vaccinations</p> <p><input type="checkbox"/> Do not feel that the vaccine(s) is necessary</p> <p><input type="checkbox"/> Due to a previous allergic reaction to the vaccine(s)</p> <p><input type="checkbox"/> Other (<i>Please state</i>) use separate sheet if necessary</p> <p>Full Name of person with Parental Responsibility:</p> <p>Signature of person with Parental Responsibility:</p> <p>Date:</p>
---

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

Office Use – Initial appropriate box(es)    No action .....    Demographic query .....    Clinical query .....    Query completed .....

