Men ACWY, Diphtheria, Tetanus & Polio Consent Form

Important information: The Diphtheria, Tetanus, Polio and Meningitis ACWY vaccines are being offered to your child and will be given at school or in a community clinic. Please ensure that you have read the accompanying information before completing this form. For further information please visit: www.kentcht.nhs.uk Should you have any questions regarding the vaccine you can contact the Immunisation Hub, by telephone: 0300 123 5205, or by e-mail: kchft.cyp-immunisationteam@nhs.net

Please complete this form for your child as fully as possible using BLOCK CAPITALS using black or blue ink.

Part One: Child Information and Contact Details

Surname:	First Name:
Date of Birth: Age:	NHS Number (*if known*):
Gender: Male ☐ Female ☐ *Please Tick as appropriate*	GP Surgery Name:
Home Address:	GP Telephone:
	GP Address:
	Post Code:
	School Name:
Post Code:	School Year: Class:

We may wish to contact you to discuss any queries. Please provide contact details

Day time contact number:	Mobile number:
Email Address:	
Would you be happy to be contacted to find out what your thoughts are about this service?	Yes ☐ No ☐
If yes, please tell us how we can contact you.	Post ☐ Email ☐

Part Two: Consent Declaration

☐ I confirm that I have parental responsibility for the above named child
I am the parent/carer (***please delete as appropriate***)
I have read and understood the information provided to me about the Men ACWY and Diphtheria, Tetanus & Polio vaccines
I understand that the information provided will be shared with my GP to update my child's health records

☐ **Yes**, I consent for my child to receive:

- **Men ACWY** ☐
- **Diphtheria, Tetanus & Polio vaccines** ☐

(***please tick vaccine as appropriate)***

Signature of Parent/Carer: _____
(***with parental responsibility***)
Print Name: _____ Date: _____

Continue to Part Three: Medical Information

☐ **No**, I DO NOT consent for my child to receive:

- **Men ACWY** ☐
- **Diphtheria, Tetanus & Polio vaccines** ☐

(***please tick vaccine as appropriate)***

Signature of Parent/Carer: _____
(***with parental responsibility***)
Print Name: _____ Date: _____

Thank you for completing this form.
Please ensure that this form is returned within 1 week of receipt in the envelope provided.

Part Three: Medical Information *(Note: this section continues overleaf)*

Please complete this section in full as any gaps may lead to the vaccine not being given. For Yes/No boxes please tick as appropriate.

Medical Questions	No	*Yes	If Yes, provide details
Do you know of any reason why your son or daughter should not be immunised? (E.g. previous LIFE THREATENING allergic reaction)	☐	☐	
Has your child ever had a severe reaction to any previous immunisation requiring medical treatment?	☐	☐	
Does your child have a medical condition? ***Please include name of condition, drugs and consultant details.***	☐	☐	
Is your child taking any medicines, steroids, inhalers or other tablets regularly? ***Please list the medication your child is on in the section overleaf.***	☐	☐	
Does your child attend a doctor or hospital clinic on a regular basis?	☐	☐	
Are there any points you would like to discuss with a nurse?	☐	☐	
Is there any other reason (not previously specified above) why your child should not be vaccinated?	☐	☐	

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Drug Name, Form and Strength	How much (Dose)	How often (Frequency)
Example: Clenil Modulite® Inhaler 100 micrograms	*2 puffs*	*Twice a day*

Ethnic Category:

A	White British	H	Asian or Asian British Indian	R	Chinese
B	White Irish	J	Asian or Asian British Pakistani	S	Any other Ethnic Group
C	Any Other White Background	K	Asian or Asian British Bangladeshi	WROM	Gypsy/Romany/Irish Traveller
D	Mixed White & Black Caribbean	L	Any other Asian Background	Z	Do not wish to disclose
E	Mixed White & Black African	M	Black or Black British Caribbean		
F	Mixed White & Asian	N	Black or Black British African		
G	Any Other Mixed Background	P	Any other Black Background		

For Office Use Only

Immunisation Checklist	YES	NO	Immunisation Checklist	YES	NO
Details correct on consent form/consent given?			Any known allergies?		
Well today?			Any possibility of pregnancy?		
Any medication/treatment (GP or Hospital)?			Advice on possible side-effect and their management?		
Any reactions to previous vaccinations?			Advice sheet given?		

Fraser Guidelines Checklist

The information below is required by the Nurses if the consent form is not signed by a parent/carer and the young person wants to receive the immunisation. A young person has competency to consent when they:	YES	NO
Understand which immunisations are to be given?		
Understand what diseases are?		
Understand the risks of not having the vaccines and the possible side-effects of the vaccine?		
Retain the information?		
Use or weigh the information provided as part of their own decision making process?		
Communicate that decision to the healthcare professional?		

Yes, I consent to the Men ACWY and/or Diphtheria, Tetanus & Polio vaccinations *(please delete as appropriate)*:

Signed:	(Child signature)	Print:	Date:
Signed:	(Nurse signature)	Print:	Date:

Vaccination Administration Details under PGD:

Vaccine Name:	Injection Site:		Batch Number & Expiry Date	Date& Time	Where administered (School, college, clinic etc.)	Name and Signature of Healthcare Professional (*please print and sign*)
Men ACWY (*circle brand given:* Menveo® / Nimenrix®)	*Circle as appropriate*					
	L arm	R arm				
Diphtheria, Tetanus & Polio (Revaxis®)	L arm	R arm				

Healthcare Professional comments/actions/additional notes:

GP Referral Information (DATE and PRINT NAME)

Referral date:	Print Name: