Shropshire Community Health NHS
NHS Trust

MENINGOCOCCAL ACWY: CONSENT TO VACCINATION

Name of proposed procedure: Meningococcal ACWY conjugate vaccination (MenACWY)

Please complete the following details, sign and return to your child's school by 8th May 2019:

Last name	**First name/s**	**Date of Birth**
Home address **Post Code**		**Daytime** contact telephone number for parent/guardian
NHS number (if known)		**Ethnicity** (see over for codes)
School/College		**Year group/form**
GP name and address		
If your child has already received this vaccine, please tell us here with the date:		
Has your child received any vaccinations in the last 12 months? If yes please give details and date:		
Has your child ever had an adverse reaction to a vaccine? If yes please give details:		
Does your child have any general health problems? Please give details:		
Is your child taking any regular medication? Please give details:		
Does your child have any allergies? Please give details:		

Statement of parent

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save the life of my child or to prevent serious harm to his or her health.

I **agree** to my child receiving the vaccination as described	I **do <u>not</u> want** my child to receive the vaccination
Signature: *Parent/Guardian with parental responsibility*	**Signature:** *Parent/Guardian with parental responsibility*
Print Name:	**Print Name:**
Date:	**Date:**

Statement of health professional;

I have explained the procedure to the patient. Information leaflets have been sent to the patient, parent/ guardian. I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient. The patient product information leaflet has been given to parent/child.

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FOR OFFICE USE ONLY

Vaccine IM 0.5 ml	Site of Injection (please circle)		Batch number/ expiry date	Immuniser (legible signature/print)	Date Vaccine Given	Time
***Menveo® 0.5 ml** ***Nimenrix® 0.5 ml**	**Left arm**	**Right arm**				

*Delete as appropriate

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DIPHTHERIA, TETANUS & POLIOMYELITIS: CONSENT TO VACCINATION

Name of proposed procedure: Diphtheria, Tetanus & Poliomyelitis vaccination (School Leaver Booster)

Please complete the following details, sign and return to your child's school by 8th May 2019:

Last name	**First name/s**	**Date of Birth**
Home address **Post Code**		**Daytime contact telephone number for parent/guardian**
NHS number (if known)		**Ethnicity (see back of form)**
School/College		**Year group/form**
GP name and address		

Statement of parent

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save the life of my child or to prevent serious harm to his or her health.

I **agree** to my child receiving the vaccination as described	I **do <u>not</u> want** my child to receive the vaccination
Signature: *Parent/Guardian with parental responsibility*	**Signature:** *Parent/Guardian with parental responsibility*
Print Name:	**Print Name:**
Date:	**Date:**

Information regarding this vaccination will be entered on the child health records, and shared with your GP practice. Please turn over and complete the questions on the back of this form where you are welcome to give further information i.e. any allergies, medical conditions and current medicines your child may be taking.

Statement of health professional;

I have explained the procedure to the patient. Information leaflets have been sent to the patient/parent/guardian. I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient. The patient product information leaflet has been given to parent/child.
In particular, I have explained:

The intended benefits; to offer protection against diphtheria, tetanus & poliomyelitis.
Possible side effects; **Very Common:** (more than 1 in 10 doses) local reactions at injection site; pain, redness, hardening of skin, swelling or nodule. **Common:** (less than 1 in 10 doses) dizziness, feeling sick, high temperature, headache. **Uncommon:** (less than 1 in 100 doses) swollen glands, feeling generally unwell, muscle pains. **Rare:** (less than 1 in 1,000 doses) joint pains, allergic reactions, see product leaflet for more information.

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FOR OFFICE USE ONLY

Vaccine	Site of Injection (please circle)		Batch number/ expiry date	Immuniser (legible signature/print)	Date Vaccine Given	Time
Revaxis (Td/IPV) 0.5 ml IM	**Left arm**	**Right arm**				