**TEENAGE VACCINATION CONSENT FORM YEAR 9 AND 10 STUDENTS**

**DIPHTHERIA/TETANUS/POLIO BOOSTER (Td/IPV) and MENINGITIS ACWY BOOSTER (MEN ACWY)**

**\* Please complete all sections and return to school for the attention of the School Immunisation Team**

**YOUNG PERSONS DETAILS – Please complete in ink:**

Surname…………………………………………………… School……………………………………………..

First names………………………………………………… Class/Form………………………………………..

Address ……………………………………………………. Home Tel………………………………………….

Postcode………………… Parents Mobile No……………………………….

D.O.B……………………… Male / Female Ethnicity… ……………………………………….

Doctor’s name/ Surgery…………………………………… Tel no………………………………………………

|  |  |  |
| --- | --- | --- |
| Has your child had a diphtheria, tetanus and polio or Menigitis ACWY vaccination in the last 5 years? | If **yes** please give details | **No** |
| Does your child have a chronic or long term condition? (particularly bleeding disorders or immunodeficiency disorders) | If **yes** please give details | **No** |
| Does your child have any severe allergies, or have they ever had a reaction to any other vaccinations they have received? | If **yes** please give details | **No** |

|  |  |
| --- | --- |
| **Consent for the vaccination** | |
| **Parental/young person consent** | **Refusal** |
| **I DO** consent to having the:   * **DIPHTHERIA/TETANUS/POLIO BOOSTER** * **MENINGITIS ACWY** | I **DO NOT** consent to having the;   * **DIPHTHERIA/TETANUS/POLIO BOOSTER** * **MENINGITIS ACWY** |
| Name | Name |
| Signature | Signature |
| Date | Date |

**Please only sign one side of the consent and complete all sections of the form then return to school ASAP**

**\*FOR OFFICE USE ONLY**

**This side to be completed by the Nurse administering the vaccine**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Site of injection**  **(please circle)** | | **Date Given** | **Batch Number & Expiry Date** | **Immuniser**  **Print** | **Immuniser signature** | **Where administered** |
| Tetanus, Diphtheria & Polio | **L arm** | **R arm** |  |  |  |  |  |
| Meningitis  ACWY Booster | **L**  **arm** | **R**  **arm** |  |  |  |  |  |