Derbyshire Community Health Services NHS
NHS Foundation Trust

Consent form

Teenage Booster (Tetanus, Diphtheria & Polio) and Meningococcal ACWY (Men ACWY)

All children in year 9 (and catch up for children up to 16) are being offered their teenage booster and Men ACWY vaccine in school if not already received

Please discuss vaccinations with your child, then **complete this form** and **return it to the school.**

Your child is able to self-consent if deemed competent.

Information about the vaccination will be put on your child's electronic health records and shared with your GP surgery. If you have any concerns, please contact the School Age Immunisation Team on (South Derbyshire) 01283 707170 (North Derbyshire) 01246 252953.

For further information on
Meningococcal ACWY go to -http://www.nhs.uk/conditions/vaccinations/pages/men-acwy-vaccine.aspx
Teenage Booster go to - http://www.nhs.uk/Conditions/vaccinations/Pages/3-in-1-teenage-booster.aspx

Child's full name (first name and surname):	Date of birth:
Home address:	Daytime contact telephone number for parent/carer:
NHS number (if known):	Ethnicity:
School:	Year group/class:
GP name and address:	

ALLERGIES AND MEDICAL CONDITIONS

All children should receive the booster except for a very small number who have had a severe life threatening reaction (i.e. anaphylaxis) to a previous dose of a vaccine containing Tetanus, Diphtheria or Polio or to the following antibiotics – Neomycin, Streptomycin and Polymyxin B. Please note that milder reactions do not count. Please record any allergic reactions and medical conditions that your child has.....
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If your child has already had their teenage booster please complete the no consent section and put already received at GP.

Consent for Teenage booster dose of Tetanus, Diphtheria & Polio (Please tick)

☐ I DO want my child to receive the Tetanus, Diphtheria & Polio vaccination

☐ I DO NOT want my child to receive the Tetanus, Diphtheria & Polio vaccination (Please provide us with the reason for this) .....

Relationship to child.....

Name: ..... Signature: ..... Date: ...../...../.....

Consent for Men ACWY (Please tick)

☐ I **DO** want my child to receive the Men ACWY vaccination

☐ I **DO NOT** want my child to receive the Men ACWY vaccination (Please provide us with the reason for this) .....

Relationship to child.....

Name: ..... Signature: ..... Date: ...../...../.....

* FOR OFFICE USE ONLY

Contra-indications checked Nurse signature & Date	Signature ..... Date	If young person consented, competent to give consent	☐ Yes ☐ No Signature .....

OFFICE USE ONLY					
Date of **Teenage booster** vaccination	Site of injection (please circle)		Batch number/ expiry date	Immuniser (please print)	Where administered (school, college, GP etc)
	L arm	**R** arm			

OFFICE USE ONLY					
Date of **MenACWY** vaccination	Site of injection (please circle)		Batch number/ expiry date	Immuniser (please print)	Where administered (school, college, GP etc)
	L arm	**R** arm			

Notes