You matter most

Harrogate and District NHS
NHS Foundation Trust

Meningococcal ACWY / Diphtheria, Tetanus and Polio Immunisation Consent Form

Parent/guardian to complete
As part of the scheduled Childhood immunisation programme a team of Nurses will be visiting schools in the next few months. They will be immunising young people against Men ACWY and DTP who have returned signed consent forms. Please note that these will be two separate injections given on the same day.
Important Information: Ensure that you and your child have read the online information advised in the cover letter.

Please return the form to school as soon as possible.

Pupil details	
Surname:	First Name:
Date of birth:	GP Practice:
Gender:	NHS Number (if known)
School	Year group and Form
Home address:	Contact phone numbers:
Please answer the following questions	
Has your child had a severe local reaction to an immunisation? Yes ☐ No ☐	
Does your child have any allergies? If so please give details below. Yes ☐ No ☐ Does your child have a bleeding disorder? Yes ☐ No ☐	
Additional parent/guardian comments regarding medical concerns:	
Consent for Men ACWY	
I consent to my son/daughter receiving: *(please tick YES or NO)* Meningitis ACWY vaccine Yes ☐ No ☐	
Consent for School Leaver Booster	
Low dose diphtheria, tetanus and inactivated polio vaccine Yes ☐ No ☐	
Name and signature of parent/guardian: *(with parental responsibility):* Date:	

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Nurse use only		
Men ACWY SystmOne check *(date/initials):*	**DTP** SystmOne check *(date/initials):*	**MMR** SystmOne check *(date/initials):*

School nurse use only

Eligibility assessment on day of vaccination.
These questions must be asked of every child and their responses noted (last question for females only)

1. Have you had any vaccinations in the last 3 weeks? If yes, which? Yes ☐ No ☐
2. Have you had any illnesses today or a temperature over 38°C? Yes ☐ No ☐
3. Do you take tablets or medicines on a regular basis? If yes which? Yes ☐ No ☐
4. Have you had a severe local reaction to a previous immunisation? Yes ☐ No ☐
5. Do you have any allergies? Yes ☐ No ☐
6. Are you or is there any reason for you to think you might be pregnant? Yes ☐ No ☐

Comments:

Vaccine details

Men ACWY

Date:	Time:	Batch Number:	Expiry date:	Site/Route:

Administered by:	SystmOne:
Comments:	

DTP:

Date:	Time:	Batch Number:	Expiry Date:	Site/Route:

Administered by:	SystmOne:
Comments	