NHS
Derbyshire Community Health Services
NHS Foundation Trust

Consent form

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

All Young people in year 9 (and catch up for young people up to age 16) are being offered their teenage booster and Meningitis ACWY vaccine

If a parent is completing this form please discuss vaccinations with your child, then **complete this form** and **return it to the school.**

Young people are able to self-consent if deemed competent.

Information about the vaccination will be put on the young person's electronic health records and shared with their 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
Meningitis 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

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 young people 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 the above named has……
……

Please complete both boxes below

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

☐ I **DO** want the above named to receive the Tetanus, Diphtheria & Polio vaccination

☐ I **DO NOT** want the above named to receive the Tetanus, Diphtheria & Polio vaccination (Please provide us with the reason for this) ……

Relationship to above named…… or self-consent ☐

Name (print): …… Signature: …… Date: ……/……/……

Consent for Meningitis ACWY (Please tick)

☐ I **DO** want the above named to receive the Meningitis ACWY vaccination

☐ I **DO NOT** want the above named to receive the Meningitis ACWY vaccination (Please provide us with the reason for this) ……

Relationship to above named …… or self-consent ☐

Name (Print): …… ……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)	Immuniser signature
	L arm	**R** arm			

OFFICE USE ONLY					
Date of **MenACWY** vaccination	Site of injection (please circle)		Batch number/ expiry date	Immuniser (please print)	Immuniser signature
	L arm	**R** arm			

Notes