Hertfordshire Community NHS
NHS Trust

Vaccination Consent Form

For Tetanus, Diptheria/Inactivated Polio Vaccine (Td/IPV) and Meningicoccal ACWY (Men ACWY)

Child's full name (*first name and surname*):	Date of Birth:	Male/Female:
Home Address:	Contact telephone number for Parent/Carer:	
NHS number *(if known):*	Ethnicity *(codes on back of form):*	
School:	Year Group/Class:	
GP name and address:		

Immunisation History

The following information is required prior to vaccination. Lack of information may result in vaccination not being given.
If your child has already received these teenage boosters please confirm the date (dd/mm/yyyy): _____/_____/_____
If you are unsure, please check with your GP.

Has your child had any serious illness, allergy or condition?	Yes	No	If yes, please specify:
Is your child taking medication?	Yes	No	If yes, please specify:
Has your child had a serious allergic reaction to previous vaccination or medication?	Yes	No	If yes, please explain how they reacted and to which medication?
Has your child had any vaccinations in the last month?	Yes	No	If yes, which vaccine and the date?

Consent Form

Please ensure that this Consent Form is signed by the parent, carer or the adult with parental responsibility (PR).

Tetanus, Diptheria and Polio (Td/IPV) Consent (Please complete either '**Yes**' or '**No**')	**Meningicoccal ACWY (Men ACWY) Consent** (Please complete either '**Yes**' or '**No**')
I want my child to receive the Td/IPV immunisation: YES Name *(print)*: .... *(Parent/Guardian)* Signature: .... Date:	I want my child to receive the Men ACWY immunisation: YES Name *(print):* .... *(Parent/Guardian)* Signature: .... Date: ....
I DO NOT want my child to receive the Td/IPV immunisation: NO Name *(print):* .... (Parent/Guardian) Signature: .... Date:	I DO NOT want my child to receive the Men ACWY immunisation: NO Name *(print):* .... (Parent/Guardian) Signature: .... Date: ....

Thank you for completing this form. Please return it to school as soon as possible.

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Name: DOB: NHS No:

FOR OFFICE USE ONLY

Vaccine Date	Site of Injection *(please circle)*		Batch Number Brand Expiry Date	Immuniser	Location
DTP (Td/IPV):	L arm	R arm			
Men ACWY:	L arm	R arm			

Date of attempted vaccination	Reason for injection not given

Post immunisation issues/adverse reactions

Date	Details	Immuniser

National Ethnic Category Codes

A White British
B White Irish
C Any other white background
D White and Black Caribbean
E White and Black African
F White and Asian
G Any other mixed background
H Indian
J Pakistani
K Bangladeshi
L Any other Asian background
M Caribbean
N African
P Any other black background
R Chinese
S Any other ethnic group
T Patient refused
W Irish Traveller
X Traveller
Y Gypsy/Romany
Z Not stated