Please complete both sides of the form

Shropshire Community Health NHS
NHS Trust

DIPHTHERIA, TETANUS & POLIOMYELITIS: CONSENT TO VACCINATION

Name of proposed procedure: Diphtheria, Tetanus & Poliomyelitis vaccination (School Leaver Booster)
Please complete the following details, sign and return to your child's school within one week:

First name	**Last name**	**Date of Birth**	
Home address **Post Code**		**School/College**	
Contact telephone number for parent/guardian		**Year Group**	**Class**
GP name and address		**NHS number (Essential)**	
If your child has already received this vaccine within the last 5 years, Please tell us here with the date:			
Has your child received any other vaccinations in the last 12 months? If yes please give details and date:			
Has your child ever had an adverse reaction to a vaccine? If yes please give details:			
Does your child have any general health problems? If yes please give details:			
Is your child taking any regular medication? If yes please give details:			
Does your child have any allergies? If yes please give details:			

Statement of parent

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save the life of my child or to prevent serious harm to his or her health.

Statement of health professional

Possible side effects of Diphtheria, Tetanus & Poliomyelitis vaccination (School Leaver Booster)

- Very Common: (more than 1 in 10 doses) local reactions at injection site; pain, redness, hardening of skin, swelling or nodule.
- Common: (less than 1 in 10 doses) dizziness, feeling sick, high temperature, headache.
- Uncommon: (less than 1 in 100 doses) swollen glands, feeling generally unwell, muscle pains.
- Rare: (less than 1 in 1,000 doses) joint pains, allergic reactions, see product leaflet for more information.

I **agree** to my child receiving the vaccination as described	I **do NOT agree** to my child to receiving the vaccination described
Print Name:	**Print Name:**
Relationship to Child/Young Person:	**Relationship to Child/Young Person:**
Signature: *Parent/Guardian with parental responsibility*	**Signature:** *Parent/Guardian with parental responsibility*
Date:	**Date:**

FOR OFFICE USE ONLY

Vaccine IM 0.5 ml	Site of Injection		Batch number/ expiry date	Immuniser (legible signature/print)	Date Vaccine Given
***Revaxis (Td/IPV) 0.5 ml IM**	**Left Arm**	**Right Arm**			

Please complete both sides of the form

Shropshire Community Health NHS
NHS Trust

MENINGOCOCCAL ACWY: CONSENT TO VACCINATION

Name of proposed procedure: Meningococcal ACWY conjugate vaccination (MenACWY)

Please complete the following details, sign and return to your child's school within one week:

First name	**Last name**	**Date of Birth**	
Home address **Post Code**		**School/College**	
Contact telephone number for parent/guardian		**Year Group**	**Class**
GP name and address		**NHS number (Essential)**	
If your child has already received this vaccine, Please tell us here with the date:			
Has your child received any other vaccinations in the last 12 months? If yes please give details and date:			
Has your child ever had an adverse reaction to a vaccine? If yes please give details:			
Does your child have any general health problems? If yes please give details:			
Is your child taking any regular medication? If yes please give details:			
Does your child have any allergies? If yes please give details:			

Statement of parent

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save the life of my child or to prevent serious harm to his or her health.

Statement of health professional

Possible side effects of Meningococcal ACWY conjugate vaccination (Men ACWY)

- Very Common: (more than 1 in 10 doses) local reactions at injection site; pain, redness, hardening of skin, swelling or nodule.
- Common: (less than 1 in 10 doses) dizziness, feeling sick, high temperature, headache.
- Uncommon: (less than 1 in 100 doses) swollen glands, feeling generally unwell, muscle pains.
- Rare: (less than 1 in 1,000 doses) joint pains, allergic reactions, see product leaflet for more information.

I **agree** to my child receiving the vaccination as described	I **do NOT agree** to my child to receiving the vaccination described
Print Name:	**Print Name:**
Relationship to Child/Young Person:	**Relationship to Child/Young Person:**
Signature: *Parent/Guardian with parental responsibility*	**Signature:** *Parent/Guardian with parental responsibility*
Date:	**Date:**

FOR OFFICE USE ONLY

Vaccine IM 0.5 ml	Site of Injection		Batch number/ expiry date	Immuniser (legible signature/print)	Date Vaccine Given
***Nimenrix® 0.5 ml IM**	**Left Arm**	**Right Arm**			