NHS
Kent Community Health
NHS Foundation Trust

Men ACWY, Diphtheria, Tetanus & Polio Consent Form

Child information and contact details			
Surname:		First Name:	
Date of Birth:	Age:	NHS Number (*if known*):	
Gender: Male ☐ Female ☐		GP Surgery Name:	
Home Address:		GP Telephone:	
		GP Address: Post Code:	
		School Name:	
Post Code:		School Year:	Class:

We may need to contact you to discuss any queries. Please provide your contact details	
Day time contact number:	Mobile number:
Email Address:	
May we contact you for feedback on our service? Yes/No (delete as appropriate) If yes, please tell us how we can contact you. Post ☐ Email ☐	

Consent declaration – you are required to tick for EACH vaccination and SIGN form	
YES, I consent for my child to receive ☐ **Meningococcal ACWY** ☐ **Diphtheria Tetanus and Polio**	☐ **No, I do not consent for my child to be vaccinated** *****You are NOT required to complete medical questionnaire *****

Medical questions - please complete in full	**No**	**Yes**	**If Yes, provide details**
Do you know of ANY reason why your son or daughter should not be immunised? E.g. previous allergic reaction			
Does your child have any medical conditions or attend a doctor or hospital clinic on a regular basis?			
Is your child taking any medicines, steroids, inhalers or other tablets regularly?			

What else would you like to tell us?

Thank you for completing this form <u>please sign below</u> and return to school as soon as possible	
If you would like to speak to one of our nurses please call 0300 123 5205 or email kchft.cyp-immunisationteam@nhs.net	
SIGNATURE OF PARENT/CARER **(with parental responsibility)** **Print Name:**	**Date:**

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Gillick Competence Self Consent Checklist. Does the young person	Yes	No
Understand which immunisations are to be given?		
Understand what diseases are?		
Understand the risks of not having the vaccines and the possible side-effects of the vaccine?		
Retain the information?		
Use or weigh the information provided as part of their own decision making process?		
Communicate that decision to the healthcare professional?		

Yes, I consent to the Men ACWY and/or Diphtheria, Tetanus & Polio vaccinations
Print name
Signed by young person Date

For Immunisation team staff use only

Vaccinator must tick	Yes	No	Vaccinator must tick	Yes	No
Details correct on consent form?			Confirm correct cohort for vaccination?		
Child understands disease being vaccinated against?			Patient information leaflet given?		
Any known allergies?			Child well today?		
Possibility of pregnancy?			Any medication or treatment?		

Vaccination Administration details

Vaccine name	Batch number & expiry date	Injection site		Date & time given	Name, Signature and designation of healthcare professional
		L arm	R arm		
Men ACWY Menveo® Nimenrix®)					
Diphtheria, Tetanus & Polio Revaxis®					

Healthcare Professional comments/actions/ additional notes