MR5tb

VACCINATION CONSENT FORM

FOR YEAR 9

DIPHTHERIA / TETANUS / POLIO / MENINGOCOCCAL ACWY VACCINES

Child's full name: (BLOCK LETTERS - *first name and surname)*	M / F	Date of Birth:
Home address: (BLOCK LETTERS) Post Code:		Daytime contact telephone number for parent/carer: Landline: Mobile:
School:	Parent email:	
GP name and surgery:		

In order to help the School Nurses ensure the safe administration of the Vaccine please complete the following:

1. Has your child got a medical condition or severe allergy for which he/she is receiving treatment? ☐ Yes ☐ No
2. Has your child had a severe reaction to an immunisation? ☐ Yes ☐ No

   *If you have answered **Yes** to either of the above questions, please give details overleaf and include dates*
3. Did your child receive the recommended baby and pre-school immunisations? ☐ Yes ☐ No

   *If responded **No**, please contact GP for advice*
4. Date/age child last had Diphtheria/Tetanus/Polio injection: .....

   NB: This date is important to ensure the correct gap is allowed between doses.

PLEASE COMPLETE BOTH BOXES BELOW AND RETURN FORM TO SCHOOL BY _____ 2019:

CONSENT FOR DIPHTHERIA/TETANUS/POLIO VACCINATION

☐ **I have read the patient information leaflet and I consent** to my child receiving the Diphtheria/Tetanus/Polio vaccination and confirm I have parental responsibility

☐ **I do not want my child to be** immunised and confirm I have parental responsibility

Signature of parent/guardian: ..... Date: .....

CONSENT FOR THE MENINGOCOCCAL ACWY VACCINATION

☐ **I have read the patient information leaflet and I consent** to my child receiving the Meningitis ACWY vaccination and confirm I have parental responsibility

☐ **I do not want my child to be** immunised and confirm I have parental responsibility

☐ My child has already had this immunisation. Date given……..

Signature of parent/guardian: ..... Date: .....

**** FOR OFFICE USE ONLY***

Date:	Site of injection: *(please circle)*		Td/Polio Batch number/expiry date:	Immuniser: *Print name*	Immuniser: *Signature*	Where administered *(School, college, GP etc)*
	Left arm	**Right** arm				

Date:	Site of injection: *(please circle)*		Men ACWY Batch number/expiry date:	Immuniser: *Print name*	Immuniser: *Signature*	Where administered *(School, college, GP etc)*
	Left arm	**Right** arm				

States of Guernsey
Children and Family
Community Services

School

The information you will provide on the Consent Form is required for the School Nursing Service for the purposes of administering immunisations. This information will be processed in line with the Data Protection (Bailiwick of Guernsey) Law, 2017. For full details of our Fair Processing Notice and how we look after your data please visit: www.gov.gg/hscprivacy if you don't have access to the internet please contact us and a paper copy will be provided.