Triaged		FAO Nurse	

Essex Partnership University
NHS Foundation Trust

Vaccination Consent Form

For Diphtheria, Tetanus and Polio (DTP) and Meningitis ACWY

Please complete in BLACK INK and return to your child's school

Child's surname	First name	Date of birth	Male ☐ Female ☐

Home address Postcode	Contact telephone numbers: Home Mobile
GP name and address NHS Number (if known)	School Tutor group

Do any of the following apply to your child:

1. Does your child have any medical conditions?	YES ☐	NO ☐
2. Are they currently taking any medications?	YES ☐	NO ☐
3. Have they had any serious adverse reactions to a previous vaccine?	YES ☐	NO ☐
4. Have they had their spleen removed or have unstable epilepsy?	YES ☐	NO ☐

If you answered **YES** to any of the above please provide details:

Diphtheria, Tetanus and Polio

In order to be fully protected your child should have received 4 immunisations protecting them against Diphtheria, Tetanus and Polio before starting school. The 5th and final DTP dose is now due.

Please can you tell us the date of your child's last Diphtheria, Tetanus and Polio vaccine *(Your child may have received this **5th** vaccine early if they had an injury)*:

.....

Details can be found in your child's red book or from your family doctor. If you are unsure we will check your child's health records and inform you if they **DO NOT** need it.

Meningitis ACWY

It is unlikely your child will have received this vaccine before unless it was as a travel vaccine or if they had their spleen removed. If they have received a Meningitis ACWY vaccine over the age of 10, please give details below.

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Measles, Mumps, Rubella (MMR

My son/daughter has received two doses of Measles, Mumps and Rubella vaccine YES ☐ NO ☐

Please ✔ the required vaccination option and complete the consent details in the boxes below - thank you

☐ **YES, I want my child to receive BOTH the DTP and Meningitis ACWY vaccinations**

OR ☐ **YES, I want my child to receive the DTP vaccination ONLY**

OR ☐ **YES, I want my child to receive the Meningitis ACWY ONLY**

Name (Print) ..... Signature .....
(Parent/Guardian)

Relationship to child ..... Date .....

EPUT 302 consent

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FOR OFFICE USE ONLY

Additional Information:

Eligibility assessment ON DAY of vaccination

CRITERIA - INELIGIBILITY Revaxis	YES	NO
Aged under 10 years of age		
Confirmed anaphylactic reaction to a previous dose of vaccine		
Confirmed anaphylactic reaction to any component of the vaccine		
Acute or febrile illness		
Evolving neurological condition e.g. unstable epilepsy until condition is stable or resolved		
Possibility of pregnancy		
No valid consent		

Additional ineligibility - Meningitis ACWY	YES	NO
Aged under 3 months or over 25 years of age		
Has received a Meningitis ACWY over the age of 10 years		
Confirmed anaphylactic reaction to a previous dose of vaccine		
Confirmed anaphylactic reaction to any component of the vaccine		
Acute or febrile illness		
Is asplenic or has a splenic dysfunction		
Meningitis C or Hib/Meningitis C vaccine administered in last 4 weeks		

If any of the answers are in the shaded boxes DO NOT vaccinate. Refer to the PGDs for appropriate action.

Eligible for Revaxis? **YES** ☐ **NO** ☐

Eligible for Meningitis ACWY? **YES** ☐ **NO** ☐

Pre-vaccination assessment completed by:

Name: .....

Designation: .....

Signature: .....

Date: .....

After you have been immunised:

- Your arm may feel uncomfortable for a few days.
- If you have any unusual symptoms please report them to your GP as soon as possible.
- Please stay in the company of the others and on the school site for at least 30 minutes.

Signature: .....

Date: .....

For official use only

Meningitis ACWY administered under PGD

Date vaccine given: ..... Time: .....

Brand: ..... Batch number: .....

Expiry date: ..... Site: L arm / R arm

Venue where administered:

School ☐

Vaccine sticker space

Clinic: .....

Nurse's signature: .....

Print name: ..... **RN** ☐

Diphtheria, Tetanus and Polio (DTP) administered under PGD

Date vaccine given: ..... Time: .....

Brand: ..... Batch number: .....

Expiry date: ..... Site: L arm / R arm

Venue where administered:

School ☐

Vaccine sticker space

Clinic: .....

Nurse's signature: .....

Print name: ..... **RN** ☐

Advice on side effects provided: YES ☐ NO ☐ Accredited written management advice provided: YES ☐ NO ☐