Please complete and sign both sides of the form and return to your child's school within one week:

Shropshire Community Health NHS Trust

MENINGOCOCCAL ACWY: CONSENT TO VACCINATION

First name	**Last name**	**Date of Birth**	**Gender**
Home address **Post Code**		**School/College**	
Contact telephone number for parent/guardian		**Year Group**	**Class**
GP name and address		**NHS number (if known)**	
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

For possible side effects and allergic reactions of Meningococcal ACWY conjugate vaccination (Men ACWY) please see product leaflet given to your child in school for more information.

GDPR For parents: This information will be shared by your child's Immunisation team for the following reasons:

1. Public Health England (PHE) to provide data to Commissioners for the immunisation service.

2. SSHIS : Staffordshire County Council's ICT department and **Shropshire** Health Informatics Service (**SSHIS**) work together to record and report data to GP's.

If you would like (further) details about the way we handle your child's information please ask for a copy of our Privacy Notice or access the Privacy Notice by going to https://www.shropscommunityhealth.nhs.uk/content/doclib/10648.pdf

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 OFFICAL USE ONLY

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

Please complete and sign both sides of the form and return to your child's school within one week:

NHS
Shropshire Community Health
NHS Trust

DIPHTHERIA, TETANUS & POLIOMYELITIS: CONSENT TO VACCINATION

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 (if known)**	
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
For possible side effects and allergic reactions of Meningococcal ACWY conjugate vaccination (Men ACWY) please see product leaflet given to your child in school for more information.
GDPR For parents: This information will be shared by your child's Immunisation team for the following reasons:
1. Public Health England (PHE) to provide data to Commissioners for the immunisation service.
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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 OFFICAL USE ONLY

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