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| **TEENAGE VACCINATION FORM****SECTION 1: Diphtheria/Tetanus/Polio Booster (Td/Ipv), Meningococcal ACWY (MenACWY) and MMR** |

**\* Please complete all sections and return to school for the attention of the immunisation Team**

**YOUNG PERSONS DETAILS – Please complete fully:**

First name ……………………………………………………… School………………………………………………

Last Name ….……………………….……………………….… Class/Form…………………………………………

Address ………………………………………………………. Home Tel………………………………………….

Postcode………………………………. Parents Mobile No……………………………….

D.O.B……………………………........... Ethnicity… …………………………………………

Gender (Male, Female, prefer not to say) ………………….

Doctor’s name/ Surgery……………………………………… Tel no……………………………………………….

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|  **SECTION 2: CONSENT FOR THE VACCINATIONS** |
| **Parental/ Guardian Consent**  |  **Self-consent (young person)** |
| I consent for my Child to have the:* **DIPHTHERIA/TETANUS/POLIO BOOSTER (combined)**
* **MENINGOCOCCAL ACWY**

In school with the school.**Please delete any immunisation you do not want given****I confirm that I have parental responsibility for this child.** | I consent to my vaccination being given in school* **DIPHTHERIA/TETANUS/POLIO BOOSTER (combined)**
* **MENINGOCOCCAL ACWY**

I have discussed and understood these immunisations with my parent/guardian and/or immunisation nurse **Please delete any immunisation you do not want given** |
| Name  | Name  |
| Signature  | Signature |
| Relationship to child | Date  |
| Date | Consent discussed with Parent /Guardian/ Nurse  |
| **SECTION 3: \*Only complete this section if you have consented to the vaccinations in Section 2** The Registered nurse will review the information you share below before giving the vaccination. Please complete this fully for the nurse to able to advise on vaccination. |
| Please circle if your Child has had any of these vaccinations in the last 5 years? | DTP MenACWY MMR HPV  |
| Does your Child have a chronic or long-term condition or taking any regular medication? | If YES**,** please give details   |
| Does your Child have any severe allergies? | If YES**,** please give details   |
| Is your Child currently seeing a doctor or receiving any treatment?  | If YES**,** please give details |

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|  **SECTION 4: MMR Vaccination (Measles, Mumps and Rubella)** |
| If your Child has missed either of the two doses of **MMR** vaccine when they were little, we would like to take this opportunity to offer a missed dose at the school vaccination session |
| There is a large increase in the number of young people catching the measles and mumps, so NHS England has advised offering the measles, mumps and rubella vaccine to **any child who has NOT received One or Two doses of MMR vaccine in the past** |
| Has your Child had 2 doses of MMR vaccine previously? **YES / NO (please circle)** *\*Children would normally have had 2 doses of MMR vaccine before their 5th birthday*  | **How many doses have already been given? (*please circle*)** **0 doses 1 dose 2 doses.**  |
| **If your Child has not had TWO doses of the MMR would you like our Nurses to give an MMR?** **YES / NO** (Please circle) | Name of consenting parent / guardian: |
| Signature: |
| Relationship: |
| Date: |

**Thank you for completing the form, please return it to school ASAP**

**FOR IMMUNISATION TEAM USE ONLY: To be completed by the Nurse administering the vaccine**

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| **Vaccination Given** | **Site of injection****(please circle)** | **Date Given** | **Batch Number & Expiry Date** | **Immuniser****Print & Sign** | **Where administered** | **PPE****Worn** |
| **Tetanus, Diphtheria & Polio Booster** | **L** **arm** | **R** **arm** |  |  |  | SCHOOLSCHOOL CATCH UPCLINIC  | YESNO |
| **Meningitis ACWY** | **L****arm** | **R****arm** |  |  |  |
| **MMR** | **L****arm** | **R****arm** |  |  |  |

**Nurse Notes**:

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| Date and Time: | Note | Print and Sign |
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