Children & Young People's Health Services SUFFOLK

NHS

School Immunisation Team

Meningitis ACWY Vaccination Consent Form

Child's Surname *(and any previous Surname):*	Child's Forename(s):	Date of Birth:
		Gender: Male ☐ Female ☐

Address & Postcode: *(please write previous address overleaf if less than 3 years)* :	Phone number of parent/guardian/carer:	
	Email of parent/guardian:	
GP's Name & Surgery Address:	NHS Number:	Ethnicity:
School Name:	Class/Form:	Year Group:

Important medical information

Has your child ever had a severe allergic reaction to any previous vaccines or medication?	**Yes*** ☐ **No** ☐
Has your child received a dose of Meningitis ACWY vaccine since the age of ten years?	**Yes*** ☐ **No** ☐

* If you answered yes to any of the above, please give details:

Consent for my child to receive the Meningitis ACWY vaccination

YES, I CONSENT: ☐		***NO, I DO NOT CONSENT:*** ☐ *(For research purposes, please give reasons overleaf if you wish)*	
Signature of parent/guardian (with parental responsibility):		Signature of parent/guardian (with parental responsibility):	
Relationship to child:	Date:	Relationship to child:	Date:

OFFICE USE ONLY

MenACWY Conjugate Vaccine, 0.5ml as per PGD	Date:	Time:	Site of IM injection (Please circle)		Batch number & Expiry date:	Immuniser:	Location:
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Nurses' Checklist:		Nurses' Comments:
Allergies		
Medication		
Recent vaccines		
Febrile illness		