NHS
Bradford District Care
NHS Foundation Trust

Immunisation Consent Form – Measles, Mumps and Rubella (MMR)

Office Use Only. NHS Number:

Name of child:	Date of birth: Sex: M/F
School:	Home address:
Child's tutor group:	Daytime contact telephone for parent/guardian:

Please note: If you do not know whether your child has received MMR previously, it is safer to be immunised rather than the risk of not being protected.

PLEASE COMPLETE THIS IMPORTANT INFORMATION	**YES**	**NO**
Does your child have a serious egg allergy?		
Has your child ever had any fits/seizures?		
Does your child have any bleeding disorders, previous reactions to vaccines or medical conditions which may affect them having this vaccine?		
If answered yes to any of the above, please provide details:		

If you change your mind after submitting this consent form or have any further queries, please contact the Immunisation Team on **01274 221203**

More information about the MMR vaccine is available from https://www.nhs.uk/Search/?q=mmr

I have read and understand the information about these vaccines.

NOTE: PLEASE RETURN THIS FORM EVEN IF YOU DO NOT CONSENT

Consent – Yes I give consent **Signature of Parent/Guardian** **……** **Date** **……** **……..**	**Refusal – No I do not give consent** **Signature of Parent/Guardian……** **Date……** **……**

If you have any complements, concerns or complaints, please let us know. We learn from all the comments we receive and use them to improve our service. If you have a concern, please contact Patient Advice and Complaints on **01274 251440** or email **advice.complaints@bdct.nhs.uk**

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Pre-session eligibility assessment for MMR: Eligible for vaccine Y N

Number of doses 1 2

If applicable – advised of 2nd dose on the post vaccine card Y

Date vaccine administered	**Batch number/Expiry Date**	**Site (Please circle)** **Left arm/Right arm**	**Given by (Please sign)**	**Location of session**