NHS

Bradford District Care

NHS Foundation Trust

Immunisation Consent Form – Diphtheria, Tetanus & Polio (DTP) and Meningococcal ACWY (MEN ACWY)

OFFICE USE ONLY. NHS Number:

Full name of child:	Date of birth:	Sex: **M / F**
	Home address:	
School:		
	Daytime contact telephone for parent/guardian:	

PLEASE COMPLETE THIS IMPORTANT INFORMATION	**YES**	**NO**
Does your child have any bleeding disorders or medical conditions which may affect them having this vaccine? Please provide details:	☐	☐
Has your child suffered any reactions to any previous vaccinations? Please provide details:	☐	☐
Please write in the box any injections your child has had within the last 4 weeks:		

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

Consent for DTP & MEN ACWY : I have read and understand the information about these vaccines.

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

☐ **Yes - I do want my child to receive these vaccinations**	☐ **No - I do not want my child to receive these vaccinations**
Signature of Parent/Guardian	**Signature of Parent/Guardian** .....
Print name of Parent/Guardian	**Print name of Parent/Guardian** .....
Date	**Date** .....

If you have any compliments, 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**

OFFICE USE ONLY

Date vaccine administered	**Given by (Name)**	**Signature**	**Location of session**
Dip/Tet/Pol **Left Arm** **Right Arm**	**Batch Number/Expiry Date**	**Men ACWY** **Left Arm** **Right Arm**	**Batch Number/Expiry Date**