Give or refuse consent for the Td/IPV vaccination (3-in-1 teenage booster)

Use BLOCK CAPITALS and a ‘tick’ or ‘x’ for boxes

Session

Date

Location

Child’s details

1 Child’s official name

Give the name on your child’s birth certificate. If it’s changed, give the name held by your child’s GP.

2 Child also known as

Tell us if they use a different name in school

3 Child’s GP surgery

4 Child’s date of birth

DD MM YYYY

5 Child’s home address

Postcode

Your details

6 Your name

7 Relationship to the child

If you’re not the child’s parent or guardian, you must have parental responsibility to give consent for the vaccination.

8 Email address

9 Telephone number

A nurse might call you about your child’s vaccination

Consent

10 Do you agree to your child having the Td/IPV vaccination?

- Yes, I agree
- No, I do not agree

11 If you do not agree, please tell us why

Health questions

12 **Does your child have a bleeding disorder or another medical condition they receive treatment for?**

☐ Yes ☐ No

If you answered yes, give details

13 **Has your child ever had a severe reaction to any medicines, including vaccines?**

☐ Yes ☐ No

If you answered yes, give details

14 **Has your child had a tetanus, diphtheria and polio vaccination in the last 5 years?**

Most children will not have had this vaccination since their 4-in-1 pre-school booster

☐ Yes ☐ No

If you answered yes, give details

15 **Does your child need extra support during vaccination sessions?**

For example, they’re autistic, or extremely anxious

☐ Yes ☐ No

If you answered yes, give details

Your signature

16 **Signed** **Date**

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