



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 |
| <input type="text"/> | <input type="text"/> |

Child’s details

| | |
|--|---|
| <div><div>1</div><div>Child’s official name</div><div>Give the name on your child’s birth certificate. If it’s changed, give the name held by your child’s GP.</div><div><input type="text"/></div><div><input type="text"/></div></div> | <div><div>4</div><div>Child’s date of birth</div><div>DD MM YYYY</div><div><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></div></div> |
| <div><div>2</div><div>Child also known as</div><div>Tell us if they use a different name in school</div><div><input type="text"/></div></div> | <div><div>5</div><div>Child’s home address</div><div><input type="text"/></div><div><input type="text"/></div><div><input type="text"/></div><div>Postcode</div><div><input type="text"/></div></div> |
| <div><div>3</div><div>Child’s GP surgery</div><div><input type="text"/></div></div> | |

Your details

| | |
|---|---|
| <div><div>6</div><div>Your name</div><div><input type="text"/></div></div> | <div><div>8</div><div>Email address</div><div><input type="text"/></div></div> |
| <div><div>7</div><div>Relationship to the child</div><div>If you’re not the child’s parent or guardian, you must have parental responsibility to give consent for the vaccination.</div><div><input type="text"/></div></div> | <div><div>9</div><div>Telephone number</div><div><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></div><div>A nurse might call you about your child’s vaccination</div></div> |

Consent

| | |
|---|---|
| <div><div>10</div><div>Do you agree to your child having Td/IPV vaccination?</div><div><div><input type="checkbox"/> Yes, I agree</div><div><input type="checkbox"/> No, I do not agree</div></div></div> | <div><div>11</div><div>If you do not agree, please tell us why</div><div><input type="text"/></div></div> |
|---|---|

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

Does your child have any severe allergies?

☐

Yes

☐

No

If you answered yes, give details

14

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

☐

Yes

☐

No

If you answered yes, give details

15

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

16

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

17

Signed

Date