MMR IMMUNISATION CONSENT FORM

PUPILS DETAILS:

Full Name of Pupil:

Pupil's Date of Birth:

Pupil's NHS number (if known):

Pupil's Address including Postcode:

Name of parent / guardian:

Relationship to pupil:

Phone number of parent / guardian:

Does your child have any medical conditions?

Does your child have any allergies?

Has your child ever had a **severe** reaction to any vaccinations previously? *(Mild fever and injection site tenderness are not included)*

Has your child received any of these vaccines in the past 4 weeks? *If Yes, please give dates.*

MMR Select

BCG Select

Mantoux tuberculin skin testing Select

Yellow Fever Select

Varicella (Chicken Pox) Select

Having read the above information and/or listened to the nurse, I agree to my child receiving the MMR vaccine.

Name of person giving consent:

Signed: Relationship to pupil:

Verbal consent given: ☐ **YES / NO** ☐

Name of Nurse taking consent:

Date:

Click here to email form or email the form to consent.wolverhampton@nhs.net

MMR IMMUNISATION CONSENT FORM

NURSES USE ONLY:

Is there any possibility of pregnancy?	Yes	No
Does the child have any allergies?	Yes	No
Is this vaccine being given with self consent? *If yes, please complete the Gillick form.*	Yes	No
Does the child have any relevant medical conditions?	Yes	No
Is the child fit and well for vaccination?	Yes	No

Date given:	Vaccination site:
Batch number:	Expiry date:
Dose Number:	
Name and signature of Nurse:	

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Batch number:	Expiry date:
Dose Number:	
Name and signature of Nurse:	