

**SCHOOL LEAVING BOOSTER IMMUNISATION**

PLEASE USE BLOCK CAPITALS

Your child is due for a TETANUS - LOW DOSE DIPHTHERIA and POLIO Immunisation Booster

Please complete and sign this consent form and return it as soon as possible to your child's school. (Addressed to the School Nurse)

|   |  |
|---|--|
| Your child's LAST name  | Your child's date of birth   |
|   |  |
| Your child's FIRST name   | Is your child <input type="checkbox"/> a boy <input type="checkbox"/> a girl |
|   |  |
| Your address  | The name and address of your family doctor (GP)                              |
|   |  |
| Postcode  | The name of their school<br>HARROW HIGH SCHOOL                               |
| Telephone No.   |  |
|   | The class or form your child is in<br>10                                     |
|   |  |
| If a Tetanus Low Dose Diphtheria and Polio Immunisation has already been carried out, state date and where this was done? |  |
|   |  |

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| Has your child any other medical condition you think important including severe chronic illness? (e.g. previous reaction to immunisation; suffers from fits, etc.) If so, give details |
|  |

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| Is your child taking any medicines now or has taken any for longer than a month in the last year? If so give details |
|  |

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|---|
| I CONSENT to my child named above being Immunised against Tetanus Low Dose Diphtheria and Polio.<br>Signed _____ (Parent/Guardian) Date _____ |
|---|

| <u>FOR HEALTH SERVICE USE ONLY</u> |  |
|------------------------------------|--|
| Date                               |  |
| Td/IPV Batch No                    |  |

|   |
|---|
| This immunisation has been given<br>Signature of Dr/School Nurse..... |
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