

Immunisation Team
Coral House
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Website: www.shropscommunityhealth.nhs.uk

November 2016

Dear Parent/Guardian

Catch up programme of Meningococcal ACWY (to protect against meningitis ACWY) immunisation for age group 01/09/2000 to 31/08/2001.

The MenACWY vaccination helps to protect your child against four types of meningococcal bacteria (groups A, C, W, and Y) that can cause meningitis (inflammation of the lining of the brain) and septicaemia (blood poisoning). These diseases are very serious especially if not diagnosed early, up to 25% of adolescents can carry the bacteria in their nose and throat without showing any signs or symptoms of the disease. Cases of meningococcal W disease have increased significantly in recent years and it is in response to this rise in cases that this vaccine has been introduced.

Please complete and return to your child's school the attached consent form, please also be aware that using Fraser guidelines, at an age of 15 years plus we are happy to accept consent directly from your child if they are fully aware of the advantages and disadvantages to vaccination.

The vaccine will be offered as a once only immunisation, a booster is not required. If you would like further information about the disease and vaccine please visit; <http://www.nhs.uk/conditions/vaccinations/pages/men-acwy-vaccine.aspx> . If you have any further questions please contact us on the above phone number or email: immunisationteam@shropcom.nhs.uk .

Yours sincerely



Carole Hales
BCG/HPV Coordinator

SCHOOL IMMUNISATION DATE:

**TUESDAY & WEDNESDAY
10TH & 11TH JANUARY 2017**

MENINGOCOCCAL ACWY: CONSENT TO VACCINATION

Name of proposed procedure: Meningococcal ACWY conjugate vaccination (MenACWY)

Please complete the following details, sign and return to your child's school within one week:

Last name	First name/s	Date of Birth
Home address		Daytime contact telephone number for parent/guardian
Post Code		
NHS number (if known)		Ethnicity (see over for codes)
School/College		Year group/form
GP name and address		
If your child has already received this vaccine, please tell us here with the date:		
Has your child received any vaccinations in the last 12 months? If yes please give details and date:		
Has your child ever had an adverse reaction to a vaccine? If yes please give details:		
Does your child have any general health problems? Please give details:		
Is your child taking any regular medication? Please give details:		
Does your child have any allergies? Please give details:		

Statement of parent

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save the life of my child or to prevent serious harm to his or her health.

I agree to my child receiving the vaccination as described	I do <u>not</u> want my child to receive the vaccination
Signature: <i>Parent/Guardian with parental responsibility</i>	Signature: <i>Parent/Guardian with parental responsibility</i>
Print Name:	Print Name:
Date:	Date:

Statement of health professional;

I have explained the procedure to the patient. Information leaflets have been sent to the patient, parent/guardian. I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient. The patient product information leaflet has been given to parent/child.

FOR OFFICE USE ONLY

Vaccine IM 0.5 ml	Site of Injection (please circle)		Batch number/ expiry date	Immuniser (legible signature/print)	Date Vaccine Given	Time
*Menveo® 0.5 ml	Left arm	Right arm				
*Nimenrix® 0.5 ml						

*Delete as appropriate

