## Consent form for vaccination against Diphtheria, Tetanus and Whooping Cough (dTp)

## To be completed by the parent/guardian

|  |  |  |
| --- | --- | --- |
| Pupil’s name | Identity number | Class |
|  |  |  |

## Questions before vaccination

|  |  |  |
| --- | --- | --- |
| **Has your child** | **Yes** | **No** |
| Any allergies? |  |  |
| Had any allergic reaction to previous vaccinations? |  |  |
| Any cronic illness? |  |  |
| In connection with wound injury received an injection for tetanus?  **If Yes**, what year? |  |  |

|  |
| --- |
| If you have answered Yes to any of the questions above, please provide additional information here: |
|  |

## Consent to vaccination

I/we have received the information and give permission for my child to be vaccinated against Diphtheria, Tetanus and Whooping Cough (dTp).

**Yes  No**

In the case of shared custody, consent is required from both guardians.

Guardian

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Parent/Guardian signature | Name (please print) | Telehone |
|  |  |  |  |

Guardian

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Parent/Guardian signature | Name (please print) | Telehone |
|  |  |  |  |

## Guardian has sole custody

Please return the completed consent form to the School nurse