Meningococcal W
Vaccination Programme

Consent Form

Family name (last name)

First name(s)

Also known as

NHI

Date of Birth Day Month Year Gender ◉ Male ○ Female

ADDRESS

Street number Flat number Rural number

Street name

Suburb or rural locality

Town, city or district

Phone number Daytime Evening Mobile

School

With which ethnic group does your child most closely identify?
(You may tick more than one)

◉ NZ European ○ Maori ○ Pacific ○ Asian
○ Other Please specify

Your Family Doctor's name Phone

Medical Centre name

Address

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Te Poari Hauora Ā Rohe O Te Tai Tokerau

*If you want your child to receive the Meningococcal W (Menactra or Nimenrix A,C,W,Y) vaccine please complete and sign the CONSENT (**AGREE**) section below.*

Aged 16 years or over? You can complete this form yourself. Remember to talk to your mum, dad, or caregiver before you decide.

Does your child have any health problems?	○ Yes ● No	*If yes, please briefly explain*
Does your child have any allergies?	○ Yes ● No	*If yes, please briefly explain*
Has your child ever had a serious problem after immunisation?	○ Yes ● No	*If yes, please briefly explain*
Has your child received any immunisations in the past month?	○ Yes ● No	*If yes, please briefly explain*

○ I have read the information pamphlet on Meningococcal W vaccine (Menactra or Nimenrix)

○ I **AGREE** to this child receiving ONE Meningococcal W Vaccine (Menactra or Nimenrix).
I am the parent/guardian or have verbal consent from the parent or guardian.

Print name	Signature	Date

YOUTH AGED 16 YEARS AND OVER – I **AGREE** to receiving the ONE Meningococcal W (Nimenrix) vaccine. I understand my doctor will be informed that I have received the vaccination.

○ I have completed this form myself and confirm I am aged 16 years or older

Print name	Signature	Date

VACCINATOR TO COMPLETE:

Please circle vaccine given: **Meningococcal W (Menactra or Nimenrix)**

Date given: Day ____ Month ____ Year ____ Time given: ____

Batch number: ____ Expiry Date: Day ____ Month ____ Year ____

Temperature: ____

Administration site: ○ Right deltoid ○ Left deltoid ○ Right vastus lateralis ○ Left vastus lateralis

Vaccinator's name: ____ Signature: ____

Adverse Reactions (describe): ____

○ Other AEFI or concern ○ Severe AEFI with anaphylaxis

○ CARM notified ○ ACC form completed

Follow up information (if required)

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Additional Information Sheet

Date

NHI

Name

1. Number of people in the following age groups living in the same household:

Age groups	Number of people	Age groups	Number of people
9 months to <5 years		20 years to 59 years	
5 years to < 13 years		60 years and over	
13 years to < 20 years			

2. How did you get to the immunisation center today?

Own car ◉ Car pooled ○ Walked ○

Kaiawhina ○ Bus ○ Friend's car ○

Other: please specify

3. How did you come to know about the MenW Immunisation Programme?

Facebook ☐ Newspaper ☐ Radio ☐

Word of mouth ☐ GP ☐ TV ☐

Northland DHB Website ☐ Ministry of Health ☐

Other: please specify

4. Information provided in regard to the MenW Immunisation Programme was:

◉ Very good ○ Good ○ Acceptable ○ Poor ○ Very poor

5. Do you have any further suggestions:

Thank you for your time

SAVE PRINT Email

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