



## School aged Immunisation Service

### **VACCINATION WITHDRAWAL OF CONSENT**

***It is extremely important this form is completed in full and returned to school prior to the immunisation session. Incomplete/inaccurate forms may result in your child being vaccinated.***

Full name of pupil: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_

Year group & class: \_\_\_\_\_

Paper or eConsent: \_\_\_\_\_

#### **Withdrawal of what vaccine**

Human Papilloma Virus ☐ Meningitis ACWY ☐ Diphtheria Tetanus Polio ☐  
MMR ☐ Flu ☐

**I have changed my mind and no longer want my child to receive the vaccination(s).**

Signed.....

Date.....

Please let us know the reason why you are withdrawing consent in the space below, this helps us plan for future sessions:

Service provided by;

