Breakspear
Medical Group Ltd

Adult vaccination/blood test consent form

Please complete all the white boxes and bring the completed form to your first appointment.

Personal Details:

First Name | Last Name

Gender: Male | Female

Date of Birth: Day | Month | Year

Contact Number | Alternate Number

Allergies: Yes* | No

*if Yes, please list:

Do you have immune deficiencies? Yes | No

Any known other conditions (please describe):

☐ **I hereby consent to be immunised against (please tick):**

- ☐ Chicken pox
- ☐ Td/IPV
- ☐ Hep A
- ☐ Hep B
- ☐ Typhoid
- ☐ Meningitis C
- ☐ Polio
- ☐ Influenza
- ☐ Other:

☐ **I hereby consent to a blood test for:**

Patient signature | **Date**

GP Name

GP Address

GP Contact Number

Next of Kin Name | Contact Number

Please check the following that apply to your immediate biological family:

- ☐ Asperger's Syndrome
- ☐ Asthma
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Eczema
- ☐ Heart problems

Other illness (please describe):

Financial Consent

This is an agreement between the Patient

(Patient's Full Name) _____ (Date of Birth) _____

of (Full Address) _____

_____

(Post Code) _____ (Telephone no.) _____

(*hereinafter to be referred to as The Patient*) and

Breakspear Medical Group Ltd,

of Hertfordshire House, Wood Lane, Hemel Hempstead, Hertfordshire, HP2 4FD *(hereinafter referred to as Breakspear Medical Group).*

The Patient hereby agrees to pay Breakspear Medical Group for consultations, treatment, tests and testing, pharmacy, vaccines and other supplies, and accommodation and meals provided at the rate applicable at the time of the treatment.

Signed by The Patient

Name: _____

Signature: _____ Date: _____

Approved on behalf of Breakspear Medical Group by:

Name: _____

Signature: _____ Date: _____

- This section is optional -

The preferred method of payment is by credit or debit card and The Patient hereby authorises Breakspear Medical Group to collect payment from their card, details of which are set out hereunder:

Credit card type: _____

Card number: _____

Expires end (mm/yy): _____ If Switch, Issue number: _____

Name as appears on card: _____

Authorised signature: _____

Breakspear Medical Group Use Only			
Date :		*Temperature:*	
General Health on day of vaccination:		*Injection site:*	
		Batch number	
		Exp Date:	
		Make:	
Vaccine Type:		*Dose:*	
Doctor's signature:	_____	*Nurse's signature:*	_____