Breakspear Hospital

ADULT VACCINATION/IMMUNISATION FORM

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

Personal Details:

First Name ____ Last Name ____

Sex — Male ☐ Female ☐

Date of Birth — Day ____ Month ____ Year ____

Allergies — Yes* ☐ No ☐

*if Yes, please list: ____

Do you have immune deficiencies? Yes ☐ No ☐

Any known other conditions (please describe): ____

Have you had any of the following vaccinations?

Triple MMR	☐	HIB	☐
Single Measles	☐	Tetanus	☐
Single Mumps	☐	Polio	☐
Single Rubella	☐	Meningitis	☐

Other (please describe): ____

GP Name ____

GP Address ____

GP Contact Number ____

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

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

Other illness (please describe): ____

Financial Consent

This is an agreement between the Patient

(Patient's Full Name) ______________________________

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 The Hospital).*

The Patient hereby agrees to pay The Hospital 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 The Hospital by:

Name: ______________________________

Signature: ______________________ Date: ____________

- This section is optional -

The preferred method of payment is by credit or debit card and The Patient hereby authorises The Hospital 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: ______________________________

Hospital 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:*	