



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 <input type="checkbox"/>		Female	<input type="checkbox"/>	
Date of Birth	Day <input type="text"/>		Month <input type="text"/>		Year <input type="text"/>
Allergies	Yes* <input type="checkbox"/>		No	<input type="checkbox"/>	
*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	<input type="checkbox"/>	HIB	<input type="checkbox"/>
Single Measles	<input type="checkbox"/>	Tetanus	<input type="checkbox"/>
Single Mumps	<input type="checkbox"/>	Polio	<input type="checkbox"/>
Single Rubella	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>
Other (please describe):			

GP Name			
GP Address			
GP Contact Number			

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

Asperger's Syndrome	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Eczema	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>
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: _____