



## CHILD Medical Questionnaire and Consent Form for BCG & Skin Test

Please complete all the white boxes and bring the completed form and your child's Developmental Book to the initial consultation.

Date of first appointment (dd/mm/yyyy)

**Child's details:**

Child's first name

Child's surname

Male

Female

Date of birth (dd/mm/yyyy)

Address

Post code

**Parent's/Guardian's details:**

First name

Surname

Contact number

Alternative

**Child's GP name**

GP address

GP contact number

**Child's condition:**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Has your child ever had a vaccination against Tuberculosis (BCG) or a recent Heaf/Mantoux skin test?                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. In the last 3 months, has your child received a high dose of steroid therapy or any other immunosuppressant medication? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Has your child been treated for leukaemia or malignant disease?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Is there any known HIV infection, including infants born to HIV positive mothers?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Has your child ever been treated for tuberculosis or is your child currently receiving TB treatment?                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. In the last 3 weeks, has your child had a severe viral infection?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. In the last 3 months, has your child had any infection needing antibiotics?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. In the last 3 months, has your child had any injection or blood transfusion?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Has your child ever had an adverse reaction to any immunisation?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Is your child suffering from a generalised skin infection or infected eczema?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Does your child have any known allergies to the vaccine components?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Has your child ever travelled outside the United Kingdom?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Has your child had any known contact with TB?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Does your child have any other medical conditions?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

*If yes, please explain.*

15. *If applicable: Date of last menstrual cycle (dd/mm/yy)*

*Vaccination will be postponed if your child has a temperature above 37.3 °C at consultation.*

I hereby consent for my child (full name) \_\_\_\_\_ to receive a skin test and a BCG immunisation or referral to a chest clinic, whichever proves necessary.

I confirm that I have parental responsibility for the child.

Signature of parent/guardian \_\_\_\_\_

Date \_\_\_\_\_

# BREAKSPEAR MEDICAL GROUP USE ONLY

## BCG Vaccination

Date	<input type="text"/>	Temperature	<input type="text"/>
Medical conditions	<input type="text"/>	Injection site	<input type="text"/>
General Health on day of vaccination	<input type="text"/>	Batch number	<input type="text"/>
Vaccine	<input type="text"/>	Dose	<input type="text"/>
		Exp date	<input type="text"/>
		Make	<input type="text"/>
Doctor's signature	<input type="text"/>	Nurse's signature	<input type="text"/>

## Mantoux Skin Test

Patient's name	<input type="text"/>	Temperature	<input type="text"/>
Batch number	<input type="text"/>	Date & time of skin test	<input type="text"/>
Manufacturer	<input type="text"/>	Exp date	<input type="text"/>
Injection site	<input type="text"/>	Dose & strength administered	<input type="text"/>
Date to be read	<input type="text"/>	Date and time test read	<input type="text"/>
Results in mm	<input type="text"/>		
Adverse reactions	<input type="text"/>		
Any blistering present	<input type="text"/>		
Any ulceration present	<input type="text"/>		
BCG required	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Referral required	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Doctor's signature	<input type="text"/>	Nurse's signature	<input type="text"/>
Any concerns	<input type="text"/>		
Notes	<input type="text"/>		