



# Child vaccination/immunisation/blood test consent form

I, hereby consent for my child, (full name of child)

Sex:  Male  Female (date of birth)

## Immunisation consent

to be immunised against (please tick):

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Single Measles *
<input type="checkbox"/> DTaP	<input type="checkbox"/> Single Rubella *
<input type="checkbox"/> Hep A	
<input type="checkbox"/> Hep B	
<input type="checkbox"/> HIB/Men C	
<input type="checkbox"/> Influenza	
<input type="checkbox"/> Meningitis C	
<input type="checkbox"/> Pneumococcal Meningitis	
<input type="checkbox"/> Polio	
<input type="checkbox"/> dTP	
<input type="checkbox"/> Typhoid	
<input type="checkbox"/> Other : <input type="text"/>	

*\* This consent section only applies to measles and rubella vaccines:*

**Special consent:** I consent to separate vaccinations of measles and rubella for my child. I am aware that the vaccines are unlicensed in the United Kingdom, but are licensed in their country of origin. Any possible risks or side effects have been fully explained to me.

**Signature of parent/ guardian:**

**Date signed:**

## Blood test consent

to have an immunisation blood test for (please tick):

<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> Rubella	<input type="checkbox"/> Other: <input type="text"/>

including local anaesthesia. I understand that it is in my child's interest that my child's limb might need to be stabilised to ensure that the needle does not puncture the rear of the vein.

I confirm that I have parental responsibility for the above mentioned child.

(Parent's or Guardian's)

Full name:

Of (full address):

Telephone number:

Signature:  Date signed:

Clinic use only			
Date :		Temperature:	
General Health on day of vaccination: Medical conditions (Refer to medical history on Child Vaccination/ Immunisation Form)		Injection site:	
		Batch number:	
		Exp Date:	
		Make:	
Vaccine:		Dose:	
Doctor's signature:		Nurse's signature:	