



Breakspear Hospital

CHILD VACCINATION/IMMUNISATION FORM

Please complete all the white boxes and bring the completed form to your child's first appointment along with your child's health record book (as different makes of vaccines may be given in different schedules).

Child's Details:

Child's First Name Child's Surname

Sex Male Female

Date of Birth Day Month Year

Allergies No Yes*

*if Yes, please list:

Parent's/Guardian's Details:

Mr Mrs Miss Ms Other:

First Name Surname

Contact Number Alternative

Does your child have immune deficiencies? No Yes

Any other known conditions (please describe):

Has your child already had any vaccinations? (Please tick the appropriate box and enter the appropriate date. If there is not enough space in the appropriate box, please add in the "Other childhood vaccinations" box below.)

	(✓)	(dd/mm/yy)		(✓)	(dd/mm/yy)		(✓)	(dd/mm/yy)
Triple MMR	<input type="checkbox"/>	<input type="text"/>	BCG	<input type="checkbox"/>	<input type="text"/>	Pertussis (whooping cough)	<input type="checkbox"/>	<input type="text"/>
Single Measles	<input type="checkbox"/>	<input type="text"/>	Tetanus	<input type="checkbox"/>	<input type="text"/>	Menitorix (Hib Men C)	<input type="checkbox"/>	<input type="text"/>
Single Mumps	<input type="checkbox"/>	<input type="text"/>	Polio	<input type="checkbox"/>	<input type="text"/>	Prevenar (PCV)	<input type="checkbox"/>	<input type="text"/>
Single Rubella	<input type="checkbox"/>	<input type="text"/>	MenC	<input type="checkbox"/>	<input type="text"/>			
HIB	<input type="checkbox"/>	<input type="text"/>	Diphtheria	<input type="checkbox"/>	<input type="text"/>			

Other childhood vaccinations:

Child's GP Name

GP Address

GP Contact Number

Please tick the following that apply to your child and/or anyone in the child's immediate biological family:

	Your Child	Child's immediate family		Your child	Child's immediate family
Autistic Spectrum	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>

Has your child any recent illnesses? No Yes If yes, please describe.

Is your child taking any regular medicines? No Yes If yes, please describe.

Is your child under the care of any consultant? No Yes If yes, please state the reason.

Please enter the appropriate value for each of the following symptoms:

Point Scale:

- 0 = Never/almost never has the symptom
- 1 = Occasionally has it, effect is not severe
- 2 = Occasionally has it, effect is severe
- 3 = Frequently has it, effect is not severe
- 4 = Frequently has it, effect is severe

Wheezing / Coughing	<input type="text"/>
Running nose	<input type="text"/>
Catarrh	<input type="text"/>
Sneezing	<input type="text"/>
Sniffling	<input type="text"/>
Recurrent earache	<input type="text"/>
Frequent throat infections	<input type="text"/>
Nasal "crease" (line across nose)	<input type="text"/>
Nose rubbing	<input type="text"/>
Itching inside the ears	<input type="text"/>
Total:	<input type="text"/>

Skin rashes	<input type="text"/>
Skin itching	<input type="text"/>
Dry skin	<input type="text"/>
Skin infections	<input type="text"/>
Total:	<input type="text"/>
Hyperactivity	<input type="text"/>
Tantrums	<input type="text"/>
Mood swings	<input type="text"/>
Abnormal sleep pattern	<input type="text"/>
Night terrors	<input type="text"/>
Poor concentration	<input type="text"/>
Headaches	<input type="text"/>
Talkativeness	<input type="text"/>
Sudden sleeping	<input type="text"/>
Total:	<input type="text"/>
Bedwetting/soiling (if toilet trained)	<input type="text"/>
Incontinence	<input type="text"/>
Frequent urination	<input type="text"/>
Pain on passing urine	<input type="text"/>
Total	<input type="text"/>

Mouth ulcers	<input type="text"/>
Coated tongue	<input type="text"/>
Patchy, sore tongue	<input type="text"/>
Bad breath	<input type="text"/>
Hiccups	<input type="text"/>
Abdominal pain	<input type="text"/>
Abdominal bloating	<input type="text"/>
Diarrhoea	<input type="text"/>
Constipation	<input type="text"/>
Total:	<input type="text"/>
Dark circles beneath the eyes	<input type="text"/>
Abnormal "milestones"	<input type="text"/>
Unexplained crying	<input type="text"/>
Aching legs	<input type="text"/>
Joint pain / swelling	<input type="text"/>
Low weight	<input type="text"/>
Abnormal weight	<input type="text"/>
Redness of the ears	<input type="text"/>
Puffiness around the eyes	<input type="text"/>
Total:	<input type="text"/>

Grand Total

Child Consent

*** This section to be completed on day of first appointment, with doctor/nurse present.***

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

to receive separate vaccinations of

<input type="checkbox"/> Measles	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Rubella	_____
<input type="checkbox"/> Mumps	
<input type="checkbox"/> All of the above	

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.

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

Mr Mrs Miss Ms Other: _____ (Parent's/Guardian's) Full name _____

Of (full address) _____

Telephone number _____

Signature of parent/guardian _____ Date signed _____

Financial Consent

This is an agreement between the Parent / Legal Guardian

(Parent or Legal Guardian Full Name) Mr Mrs Miss Ms
Other:

of (Full Address)

(Post Code)

(Telephone Number)

of the child (Full Name)

(Child's Date of Birth dd/mm/yy)

(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 Parent or Guardian hereby agrees to pay The Hospital for medicines and medical services provided at the rate applicable at the time of the treatment.

Signed by Parent or Legal Guardian on behalf of The Patient

Name: Mr Mrs Miss Ms
Other:

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 Parent or Guardian hereby authorises The Hospital to collect payment from their card, details of which are set out hereunder:

Credit card details:

Type of card*: Visa Mastercard Debit card

Card number:

Validity period (mm/yy):

If Switch, Issue number:

Name as appears on card:

Authorised signature:

* Note: we do not accept payment by AMEX or cheques.

Hospital Use Only

The order that the vaccines are administered may vary. They are stand-alone vaccines.

MEASLES

First vaccine Booster

Date (dd/mm/yy):

Inform Parent or Guardian of the possible adverse reactions:

Hyperthermia

Mild rash

Live vaccine

Interval between doses (4 weeks minimum, maximum undefined 1-4 years)

Rhino-pharyngeal / respiratory symptoms

No known case of transmission

Contains casein (milk)

Milk sensitivity (recommended immunisation; see other form)

Data Sheet given

Child's temperature

Any concerns

Doctor/Nurse signature

Make Batch:

Expiry date (dd/mm/yy) Injection site:

RUBELLA

First vaccine Booster

Date (dd/mm/yy):

Inform Parent or Guardian of the possible adverse reactions:

Hyperthermia

Mild rash

Live vaccine

Interval between doses (4 weeks minimum, maximum undefined 1-4 years)

Swollen or painful joints

Swollen glands — posterior cervical

May contain casein (milk)

Milk sensitivity (recommended immunisation; see other form)

Data Sheet given

Child's temperature

Any concerns

Doctor/Nurse signature

Make Batch:

Expiry Date (dd/mm/yy) Injection site:

MUMPS

First vaccine Booster

Date (dd/mm/yy):

Inform Parent or Guardian of the possible adverse reactions:

Anaphylaxis if sensitive to egg

Hyperthermia

Gastrointestinal symptoms

Live vaccine

Interval between doses (4 weeks minimum, maximum undefined 1-4 years)

Malaise

Catarrh

Contains egg

May contain casein (milk)

Egg & milk sensitivity (recommended immunisation; see other form)

Data Sheet given

Child's temperature

Any concerns

Doctor/Nurse signature

Make Batch:

Expiry Date (dd/mm/yy) Injection site: