Breakspear

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			BCG			Pertussis (whooping cough)		
Single Measles			Tetanus			Menitorix (Hib Men C)		
Single Mumps			Polio			Prevenar (PCV)		
Single Rubella			MenC					
HIB			Diphtheria					

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			Diabetes		
Asthma			Eczema		
Crohn's Disease			Heart problems		

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

Symptom	Value
Wheezing / Coughing	
Running nose	
Catarrh	
Sneezing	
Sniffling	
Recurrent earache	
Frequent throat infections	
Nasal "crease" (line across nose)	
Nose rubbing	
Itching inside the ears	
Total:	

Symptom	Value
Skin rashes	
Skin itching	
Dry skin	
Skin infections	
Total:	

Symptom	Value
Hyperactivity	
Tantrums	
Mood swings	
Abnormal sleep pattern	
Night terrors	
Poor concentration	
Headaches	
Talkativeness	
Sudden sleeping	
Total:	

Symptom	Value
Bedwetting/soiling (if toilet trained)	
Incontinence	
Frequent urination	
Pain on passing urine	
Total	

Symptom	Value
Mouth ulcers	
Coated tongue	
Patchy, sore tongue	
Bad breath	
Hiccups	
Abdominal pain	
Abdominal bloating	
Diarrhoea	
Constipation	
Total:	

Symptom	Value
Dark circles beneath the eyes	
Abnormal "milestones"	
Unexplained crying	
Aching legs	
Joint pain / swelling	
Low weight	
Abnormal weight	
Redness of the ears	
Puffiness around the eyes	
Total:	

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

- ☐ Measles
- ☐ Rubella
- ☐ Mumps
- ☐ All of the above
- ☐ Other: ______________________________

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 Clinic).*

The Parent or Guardian hereby agrees to pay The Clinic 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 Clinic 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 Clinic 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.

Clinic 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: