Breakspear Hospital

CHILD VACCINATION/IMMUNISATION FORM

Please complete all the white boxes and bring the completed form to your child's first appointment.

Child's Details:

Child's First Name		Child's Last Name			
Sex	Male		Female		
Date of Birth	Day		Month		Year	
Allergies	Yes*		No		
*if Yes, please list:					

Parent's/Guardian's Details:

First Name		Last Name	
Contact Number		Alternative	

Does your child have immune deficiencies? Yes ☐ No ☐

Any known other conditions (please describe):

Has your child already had any vaccinations? (Please check the appropriate box.)

Triple MMR	☐	HIB	☐
Single Measles	☐	Tetanus	☐
Single Mumps	☐	Polio	☐
Single Rubella	☐	Meningitis	☐

Other (please describe):

~~*For children already immunised, Breakspear Medical Group does not recommend that further Measles, Rubella or Mumps injections be given without having the blood tested first.*~~

Child's GP Name	
GP Address	
GP Contact Number	

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

	Your Child	Child's immediate family
Asperger's Syndrome	☐	☐
Asthma	☐	☐
Crohn's Disease	☐	☐
Diabetes	☐	☐
Eczema	☐	☐
Heart problems	☐	☐

Other illness (please describe):

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

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

Skin rashes	
Skin itching	
Dry skin	
Skin infections	
Total:	

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

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

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

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

Financial Consent Form

This is an agreement between the Parent / Legal Guardian

(Parent or Legal Guardian Full Name) _____

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 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 Parent or Legal Guardian on behalf of 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 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: _____

Validity period (mm/yy): _____ If Switch, Issue number: _____

Card number: _____

Name as appears on card: _____

Authorised signature: _____

Hospital Use Only

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

MEASLES

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

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

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: ☐