

CONSENT FOR CHILDHOOD IMMUNISATION

Child's Name:

DOB:

NHS No:

I, (Print name) _____ give my consent
for my child, named above to have the following vaccinations today:

Name of vaccines

Please answer the following questions:

Is the child well today? Yes No

Is the child receiving any medications or treatments that could
effect their immune system? Yes No

Does the child have any allergies including allergies to eggs or
antibiotics? Yes No

Has the child had any adverse reaction to other vaccinations? Yes No

Does the child's family, friends or close contacts have a reduced
immune system as a result of disease or treatment? Yes No

I have read the relevant Manufacturers Information leaflets
(available to pick up from surgery) Yes

Signed:

Date:

Relationship: Mother Father Legal Guardian

Staff - to be scanned onto patient notes (IS code: CFCI)

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