**Parental Consent** **Well Street Medical Centre**
For Childhood Immunisation & Vaccination

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**When is this form required?**
If a parent or legal guardian of a child cannot accompany the child to the surgery for their vaccinations, this form **MUST** be completed fully.

**If I can bring my own child to the surgery do I need to complete the form? NO**

**What happens if I arrive without the form being completed fully?**
We are unable to give any vaccinations. A new appointment will have to be arranged which will delay the completion your child's vaccinations.

**Do I need a form for each of my children?**
**Yes.** We need your consent and required details for each child. The form is attached to your child's records so a separate form is required for each of your children requiring vaccinations.

I consent to my child [insert child's full name] _____,
Child's date of birth: _____ having the following vaccinations;

**Please tick** the appropriate vaccination your child requires:

| **The Routine Immunisation Schedule (autumn 2018 onwards)** | |
|---|---|
| **Age Due** | **Diseases Protected Against** |
| ☐ 2 months | 1st Diptheria, Tetanus, Pertussis, Hib, Inactivated Polio and Hepatitis B<br>Pneumococcal<br>Meningococcal group B<br>Rotavirus |
| ☐ 3 months | 2nd Diptheria, Tetanus, Pertussis, Hib, Polio and Hepatitis B<br>Rotavirus |
| ☐ 4 months | 3rd Diptheria, Tetanus, Pertussis, Hib, Polio and Hepatitis B<br>Pneumococcal<br>Meningococcal group B |
| ☐ 12 – 13 months | Hib and Men C<br>Pneumococcal<br>1st Measles, Mumps and Rubella |
| ☐ 3 years 4 months | 2nd Measles, Mumps and Rubella<br>Diptheria, Tetanus, Pertussis, and Polio |

| **Seasonal Influenza Nasal Spray / Vaccination** |
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| ☐ I consent for my child to receive the flu immunisation. |

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Telephone number of the parent who can be contacted at the time of the vaccination if needed:

Full name of parent or legal guardian: _____

Contact telephone number: _____

Any concerns or problems arisen from past vaccinations YES/NO (please delete)
If YES – what happened?

_____

_____

Has your child any allergies? YES/NO (please delete)
If Yes – to what?

_____

_____

Name and relationship of the person bringing your child into the child vaccination clinic:

_____

Any further parental comments:

**Signed: …… (PARENT/LEGAL GUARDIAN)**

**Print Name: …….**

**Date: ……**