

**Single Vaccination Programme  
Registration Form**

<b>PARENT/ GUARDIAN DETAILS</b>	Mr/Mrs/Ms/Miss	Name by which you prefer to be addressed
	Forename(s)	Surname
Address		Telephone (daytime)
		Telephone (evening)
Email address		Mobile phone
<b>YOUR CHILD'S DETAILS</b>	Forename(s)	Date of Birth
	Surname	Male/Female
Was your child premature? YES/NO		
If Yes no of weeks ..... Weight (kg) .....		
Is your child generally in good health? YES/NO		Has your child been free from serious illness, accidents or operations in the past? YES/NO
If you have answered NO to either of the previous questions, please give full details below		
<p>What vaccinations has your child already had?</p> <p>                     Combined MMR <input type="checkbox"/>    Single Measles <input type="checkbox"/>    Single Mumps <input type="checkbox"/>    Single Rubella <input type="checkbox"/>                      Diphtheria (DIP) <input type="checkbox"/>    Tetanus <input type="checkbox"/>    HIB <input type="checkbox"/>    Polio <input type="checkbox"/>                      Meningitis C <input type="checkbox"/>    Whooping Cough <input type="checkbox"/>    Chicken Pox <input type="checkbox"/>    Pneumococcal <input type="checkbox"/>                      Other <input type="checkbox"/>    details .....                 </p>		
Has your child ever had any adverse reaction to any vaccination? (If yes, please describe)		
Is your child currently taking any regular medications? (If yes, please describe)		
Does your child suffer from any allergies to medicines or to foods? (If yes, please describe)		
Does your child have any of the following? (Please circle for YES)		
Diabetes / asthma / thyroid problems / rheumatism / eczema / Crohns / any bowel disease / Aspergers / Behavioural disorder		
<p><b>PLEASE NOTE</b>                      Impaired immunity, history of anaphylactoid reactions to eggs or the antibiotic 'Neomycin' are contraindications to these vaccines.                      Immunisation is not advisable if a fever is present (due to an acute infection).                      Please ensure that you answer the above questions, as immunization may not be possible due to a permanent contraindication.</p>		

<b>Name and Address of GP</b>	<b>GP's Telephone Number</b>
<b>Name and Address of School (if applicable)</b>	<b>School Telephone Number</b>
<b>CONSENT AND DISCLAIMER</b>	
<p>I confirm that I am the person named in the first part of this form and that I have parental responsibility of the child whose details are given. I understand that this registration must be approved by Clarion Health's doctor before my child can be enrolled on the Single Vaccination Programme. I am aware of the cost of the Programme and that this must be paid in full either at the first appointment or over the first two visits to the clinic. It is my intention that my child will complete the full course of three vaccinations unless otherwise agreed with the doctor and that no refund will be given unless the doctor decides that it is unwise to complete the programme for reasons of medical safety. I <b>do/do not</b> (please delete) give my permission for Clarion Health to contact my child's GP whose details I have given.</p> <p>I give consent for my child ..... to undertake the course of single vaccinations for Measles, Mumps and Rubella at Clarion Health Ltd.</p> <p>I understand that the vaccines used are on a 'named patient basis' as they are currently not licensed for single use in the United Kingdom and that they are to be administered by Clarion Health to my child. I understand that treatment will be given using all due care and attention and that Clarion Health operates under guidelines, policies and procedures as laid down by the Healthcare Commission.</p> <p>Signed ..... Date .....</p> <p>(Parent/Guardian)</p> <p>Name .....</p> <p>(please print name)</p>	
<p>HOW DID YOU HEAR ABOUT CLARION HEALTH? (please circle)</p> <p>Family/Friends      Internet      JABS      GP/Health Visitor      Leaflet/Poster      Advertisement (please state publication)</p> <p>HOW EASY/DIFFICULT WAS IT TO FIND OUT ABOUT THE SINGLE VACCINATION PROGRAMME? (Please circle – 1: very easy    5: very difficult)</p> <p style="text-align: center;">1            2            3            4            5</p>	
<p>If you have concerns about your child's suitability for the Programme which you would first like to discuss with our doctor, put them in writing and put an x in this box – but do note that this may cause some delay in scheduling your first appointment. <span style="float: right;"><input type="checkbox"/></span></p>	
<p><b>Thank you for enrolling your child on Clarion Health's Single Vaccination Programme. We will contact you to arrange your first appointment as soon as our doctor has approved your registration.</b></p>	

<b>FOR COMPLETION AT THE CLINIC ONLY</b>
<p><b>DOCTOR/NURSE</b></p> <p>I confirm that I have explained the procedure to the Parents/Guardians including the benefits, risks, side effects and alternative treatments (including no treatment). I have confirmed with the Child's Parents/Guardians that they have no further questions and wish for the procedure to go ahead.</p> <p>Signed ..... Date .....</p>
<p><b>PARENT/GUARDIAN</b></p> <p>I confirm that I have had the consultation with the doctor/nurse and that I have had the full course of treatment explained to me, including the benefits, risks, possible side effects, alternative treatments (including no treatment) and that any particular concerns that I have raised have been addressed. I confirm that I wish for my child to proceed with the course of single measles, mumps and rubella vaccinations.</p> <p>Signed ..... Date .....</p>