

Vaccine Ireland | Vaccination Consent Form

On each visit to the clinic you will be asked to complete an '**On The Day' Medical Form** to assess your child's health and fitness. If you answer yes to any of the questions it may mean we postpone vaccination until your child is fit and well.

The person(s) with parental responsibility must complete the **Registration Form** and sign the **Vaccination Consent Form**.

If parents/guardian are unable to accompany child on day of vaccination and wish another adult to attend in loco parantis then written consent must be given and brought to the appointment.

Any vaccine administered will be checked with parents/guardian prior to vaccination. The date of vaccination, injection site, vaccine manufacturer, actual vaccine given (e.g. measles, expiry date and batch number) will be recorded in the child's file and a copy given to parents/guardian.

As usual following any vaccination you are requested to remain in the waiting area for 10/15 minutes observation.

Vaccination aftercare will be discussed and a telephone advice line number given to you should you require advice or have any concerns regarding your child's health after vaccination. The advice line will operate between 8a.m. and 10p.m. every day.

The '**Vaccination Consent**' must be signed by the person(s) with parental responsibility for this child.

I/we have parental responsibility for _____ and confirm receipt of a vaccine information pack and that I/we have had the opportunity to discuss the vaccination with a Vaccine Ireland health professional.

I/we hereby consent to the administration of the course of single Measles, Rubella and Mumps vaccines.

Signature _____ Date _____

Signature _____ Date _____



Single Measle/Mumps/Rubella Vaccines, Registration Form

Child's Details

Male _____ Female _____

First Name(s) _____

Surname _____

Date of Birth _____

Parent/Guardian Details _____

First Name _____

Surname _____

Address _____

Telephone Daytime _____ Evening _____

Mobile _____

Email _____

Doctors Name _____

Address _____

Telephone _____

Email _____



CHILD'S MEDICAL QUESTIONNAIRE

First Name: _____

Surname: _____

Date of Birth: _____

BIRTH DETAILS:

Premature NO _____ YES _____ WEEKS

Normal Delivery NO _____ YES _____

Caesarean NO _____ YES _____

Birth Weight _____

Is your child up to date with their childhood Immunisations

YES _____ NO _____

DOES YOUR CHILD SUFFER FROM ANY OF THE FOLLOWING:

Diabetes NO _____ YES _____

Heart Disease NO _____ YES _____

Asthma NO _____ YES _____

Allergies (ie Eggs) NO _____ YES _____

Any other illness _____

Has your child had any operations? NO _____ YES _____

Is your child on any medication? NO _____ YES _____

Family medical history: (please give details)

Diabetes, Heart disease, Asthma, allergies or any other illness:

