Praze & Connor Downs Surgeries

Dr J Ellery · Dr S Quick · Dr A Ellery · Dr J Edgcumbe · Dr K Gibbins

Child Vaccination

Please fill out the following questionnaire prior to appointment:

Name of Patient: _____

D.O.B _____

Address:

_____

Contact Number: _____

Name of Person attending with patient today: _____

Relationship to patient: _____

	YES	NO
Do you have Parental Responsibility?		

Please Note: A Guardian bringing a Child or Baby for vaccination who does not have parental responsibility will require bringing written and signed letter, consenting for the vaccination from the legal guardian.

Please tick the following boxes:

	YES	NO
1) Has the Patient had a 6-8 week check with the Doctor?		
2) Is your child fit and well today?		
3) Any Allergies known? ***If yes, please state below:*** _____		
4) Any Previous Reactions to vaccines? ***If yes, please state below:*** _____		

Rotavirus Vaccine

	YES	NO
5) Was the patient born with intussusception?		
6) Do any family members have a lowered immune system?		

***Signed*_____**

***Printed Name*_____**

***Date*_____**