Last reviewed 09/05/2018

PARK PRIVATE CLINIC – Vaccination Form

Please write clearly and in BLOCK CAPITALS

Forename: _____ Surname: _____

Address: _____ Post Code: _____

Tel No: _____ Gender: _____ DOB: _____

Email Address: _____

How did you hear about us? Search Engine ☐ Word of Mouth ☐ Social Media ☐ Leaflets/Flyer ☐ Other? State: _____

Please tick if you DO NOT want to be added to our mailing list for marketing purposes

Are you suffering from any minor ailments? No ☐ Yes: ☐ State: _____

Do you have any long term medical conditions? No ☐ Yes: ☐ _____

Do you take any regular medication? No ☐ Yes: ☐ _____

Have you recently taken antibiotics or steroids? No ☐ Yes: ☐ _____

Do you suffer from anxiety, depression or other psychological illness?

No ☐ Yes: ☐ _____

Have you received treatment for chemotherapy or radiotherapy? No ☐ Yes ☐

Do you have any problems with your liver or kidneys? No ☐ Yes: ☐ _____

Do you have any allergies (including eggs)? No ☐ Yes: ☐ _____

Have you had a bad reaction to vaccines previously? No ☐ Yes ☐ Are you HIV positive? No ☐ Yes ☐

Have you had your spleen removed? No ☐ Yes ☐ Do you suffer from Epilepsy? No ☐ Yes ☐

Have you had a live vaccine with the last 28 days? No ☐ Yes: ☐ _____

(Live vaccines are: Yellow Fever, BCG, MMR, Chicken Pox, Rotavirus, Influenza, Oral Polio)

If YES, please state the vaccine and date you had it: _____

Women only: Are you pregnant, trying to conceive or breastfeeding? No ☐ Yes ☐

Have you checked with your NHS GP?
Childhood vaccinations, flu vaccines, shingles, pneumococcal, Hepatitis B, Chicken Pox and some travel vaccines can be free on the NHS for those that meet the criteria.

- **By singing this form I agree to make payment for the services received today at Park Private Clinic as per published prices.**

(Our prices can be found on our website, in the waiting room or you can ask a member of staff)

Signature: _____ **Name:** _____ **Date:** _____

Relationship to patient (if not the patient): _____

PLEASE CONTINUE OVERLEAF

Forename: _____ **Surname:** _____ **DOB:** _____

Previous vaccination history (please give dates if known):

Vaccinations	Date/s	Vaccinations cont.	Date/s
BCG (TB)		HPV (Gardasil)	
Chicken Pox		Meningococcal ACWY	
Diphtheria/Tetanus/Polio		Meningitis B	
Flu / Swine Flu		MMR	
Hepatitis A		Steroid Injection	
Hepatitis B		Shingles	

FOR DR'S / PARK PRIVATE CLINIC USE ONLY

Date	Vaccine	Dose (1st/2nd/3rd/Booster)	Batch No/Expiry Date	Site Given	Signature	Price

- ☐ **No contraindications**
- ☐ **Post treatment observation**
- ☐ **Post treatment discussed potential side effects**
- ☐ **Written advice**
- ☐ **Discussed other vaccines and diseases**