



Vaccination Registration Form: Client Copy

Please read the enclosed vaccine information and retain for your records. Fill the 3 page Clinic Copy form and send to the address below with the registration fee if applicable.

Thank you for expressing an interest in the vaccination services offered by Direct Remedies.

The registration process helps to ensure that clients / their children are fully informed of the vaccine and its relevant characteristics such as side effects etc.

It is also extremely useful to have medical and vaccination history for our clinical staff to consider in some detail when planning a vaccination course or deciding on the safety of a particular product for you or your child.

Benefits.

It is an advantage to be able to appreciate the precise degree of protection offered by the vaccines that you are choosing to have. We must emphasise that no vaccine stimulates 100% immunity throughout life. The percentage protection is usually more than 90% for most vaccines but can be as low as 60% in case of the BCG jab.

Some vaccines only cover for certain specific strains of a bacteria or virus. When you read the relevant vaccine information it will be explained in more specific detail.

Boosters and Dosing Schedule.

Most vaccines do not offer lifelong immunity without boosters at appropriate intervals. Please ensure that you are familiar with the schedule for booster for the vaccine(s) that you are interested in.

For some very recent vaccines that have only just been released to healthcare, the need for boosters has not yet been elucidated. In such cases we will keep you updated on our website as manufacturers and research reveals the required schedule.

Risks or side-effects.

Vaccines, like all other medical products, have recognized side effects. While a lot of these are thought to be directly caused by the injected vaccine, other side effects are quite simply loose associations which may have occurred in recipients by chance. They are all important to note in order to make an informed choice. The most common and most severe risks of vaccines in general are:

- Injection site reactions such as swelling, or redness,
- fever (>38°C/100.4°F),
- irritability, drowsiness, restless sleep,
- decreased appetite, vomiting and/or diarrhoea,
- rash or hives,
- Severe, rare allergic reactions,
- Brain inflammation, bone marrow failure (extremely rare)

Please call to clarify any details or discuss with our doctor if required.

Approved and Written: Dr.D.D.Ratnasinghe.

Jan. 2007.

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(Please fill this form, sign the authorisation at the end and return to the address below. Leave the last page blank to be filled and signed for consent during each clinic visit)

Parent/Guardian/Client Details: Surname: Mr/Mrs/Miss* _____

First Name(s): _____ Tel: Landline: _____ . Mobile: _____

Address: _____

_____. Postcode: _____ . E-mail: _____

Child (If applicable) : Details: Surname: _____

First Name(s): _____ . Date of Birth: _____ . Male / Female*

GP Details: If you would like us to inform your family doctor of the vaccinations you/your child has received, please supply:

Name of Doctor : _____ Tel No.: _____

Address: _____

_____. Post Code: _____

Child/Client's Vaccination History: What vaccinations have you/your child already had? (Please circle)

Diphtheria (DIP) / Tetanus (TET)/ Whooping Cough (PER) / HIB / BCG / Polio / Men C / Other _____

Single Rubella / Single Measles / Single Mumps/ Hep B / Chickenpox / Pnemococcal / Flu / Combined MMR

Any vaccine complications? _____

Family Medical History: Do any of the following illnesses occur in the family? (Please circle)

NONE / Diabetes / Asthma / Crohns / Other bowel disease / Thyroid disease / Cancers / Eczema / Severe allergies

Aspergers / Autism / ADHD / Behavioural disorders / Blood disorders. / Rheumatological disease / Others _____

How is your child/yourself related to the relevant person/people above?

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Your/ your child's Health Record

Have you/your child been diagnosed with any of the following? (Please circle) **NONE** / **Eczema** / Crohns / Other bowel disease /

Aspergers / Autism / ADHD / Diabetes / Asthma / Thyroid disease / Blood disorder / Malignancy (cancer) / **Other**

Any surgical operations? Yes / No*. If yes, details: _____

What is your/your child's current general health?

Any current medications? Yes / No*. If yes, details: _____

(Certain steroids and cancer treatments are particularly important to note)

Any known allergies? Yes / No*. If yes, details: _____

Clinic Venue / Location: Please indicate the name of the clinic venue or location you wish to attend.

Sunbury Clinic (London) ___ Brighton Clinic ___ Glasgow Clinic ___ Newcastle Clinic ___ York Clinic ___ Bristol Clinic ___

Manchester Clinic___ Peterborough Clinic___ Exeter Clinic___ Dartford Clinic ___ Aberdeen Clinic ___ Other Clinic ___

Authorisation and Confirmation: (Signing this section gives us permission to process your application fully)

I authorise Dr.D.D.Ratnasinghe to safeguard and store my / our records in paper and electronic form (Please note that the information will only be used to organise safe and smooth vaccination sessions for you/your child and to conduct internal audits as necessary: all in accordance with the Data Protection Act). Yes / No*

I confirm that Dr.D.D.Ratnasinghe may import the vaccines on my own/ my child's behalf in accordance with the relevant approved processes. Yes / No*

Signature of Parent / Guardian / Client: _____ Date: _____

Yours Reasons (Optional): Finally, please share with us your reasons for choosing this vaccine.

Note: Please send this application form **Direct Remedies Ltd, The Sunbury Clinic, 2 Burgoyne Road, Sunbury-on-Thames, Middlesex, TW16 7PW.**

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CLINIC USE ONLY

Name of Client/Child: _____ Date of Birth _____

1st Vaccine: Vaccination: _____ Date: _____ Location: _____
Brand Name: _____ Lot/Batch no: _____ Exp Date: _____
Fit for Vaccination Yes / No* Site of Injection: _____

* Delete where not applicable

*I am the parent / legal guardian of the above-named child/ I confirm that all relevant information about the vaccination has been given to me and fully understood by me. I have been given the opportunity to consider the decision and ask any further questions from the doctor or nurse as necessary. **I do consent to my child/me receiving the above vaccine.**

Name: _____ Signature: _____ Date: _____

I Dr/Mr/Ms: _____ hereby declare that the above is a true reflection of the informed consent process. All relevant information and outstanding questions have been addressed.

Signature of doctor / nurse: _____ Date: _____

2nd Vaccine: Vaccination: _____ Date: _____ Location: _____
Brand Name: _____ Lot/Batch no: _____ Exp Date: _____
Fit for Vaccination Yes / No* Site of Injection: _____

* Delete where not applicable

*I am the parent / legal guardian of the above-named child/ I confirm that all relevant information about the vaccination has been given to me and fully understood by me. I have been given the opportunity to consider the decision and ask any further questions from the doctor or nurse as necessary. **I do consent to my child/me receiving the above vaccine.**

Name: _____ Signature: _____ Date: _____

I Dr/Mr/Ms: _____ hereby declare that the above is a true reflection of the informed consent process. All relevant information and outstanding questions have been addressed.

Signature of doctor / nurse: _____ Date: _____

3rd Vaccine: Vaccination: _____ Date: _____ Location: _____
Brand Name: _____ Lot/Batch no: _____ Exp Date: _____
Fit for Vaccination Yes / No* Site of Injection: _____

* Delete where not applicable

*I am the parent / legal guardian of the above-named child/ I confirm that all relevant information about the vaccination has been given to me and fully understood by me. I have been given the opportunity to consider the decision and ask any further questions from the doctor or nurse as necessary. **I do consent to my child/me receiving the above vaccine.**

Name: _____ Signature: _____ Date: _____

I Dr/Mr/Ms: _____ hereby declare that the above is a true reflection of the informed consent process. All relevant information and outstanding questions have been addressed.

Signature of doctor / nurse: _____ Date: _____