

**Direct Remedies**

'Keeping you safe by choice'

**Contact: 0845 130 4595 or [jabs@directremedies.com](mailto:jabs@directremedies.com)**

**VARIVAX- Live Attenuated Chickenpox Vaccine.**  
**(Varicella-Zoster Vaccine)**

This is the brand of vaccine used by us to immunise against chickenpox, which is a common (but sometimes potentially devastating) illness with a rash, fever, sore throat, aches and poor appetite. The rash itself progresses to fluid filled blisters that become crusty before healing.

Chickenpox is caused by the varicella-zoster virus. It is spread by direct contact with the blisters or by breathing the air with virus in droplets (from coughing). It can also pass down from an infected mother to her foetus.

Rare complications of chickenpox include, shingles, encephalitis (brain inflammation) and pneumonia. Adults are particularly vulnerable to the severe complications of chickenpox pneumonia.

The vaccine and benefits: Varivax is a live attenuated vaccine. It is manufactured and marketed by Sanofi-Pasteur MSD Limited and made in the Netherlands. It contains a small quantity of live weakened chickenpox viruses (Oka/Merck strain cultured on human diploid cells) which stimulate the production of antibodies. It is thus highly effective in preventing the disease.

As with other vaccines it does not completely protect all individuals from catching chickenpox, but those who do develop the disease usually have a very mild illness with fewer spots and blisters.

Varivax can protect an individual who has been potentially infected with chickenpox from developing the disease if given within 3 days of contact with a patient. In this scenario it could either prevent the illness or reduce the severity.

It can be administered to children (over 12 months of age) and adults.

Risks: the following points need to be carefully considered with concerns discussed with the consultant or your doctor.

- The presence of a severe infection with a high temperature would make it dangerous to administer the vaccine until there is full recovery from the illness (A minor infection such as a cold or cough would not be a problem).
- A severe allergy to VARIVAX, or any ingredient contained (e.g. hydrolysed gelatine, neomycin sulphate, monosodium glutamate and urea) can potentially cause anaphylaxis with shortness of breath, collapse and shock.
- Having a low white blood cell count or problems with the immune system could pose an unacceptable risk for the recipient: please discuss with the nurse or doctor.
- Taking medicines that alter the immune system such as steroids and cancer treatment can pose added risks
- Having active TB, HIV or Immunity problems can also pose increased risks
- In rare cases the vaccine has resulted in actual chickenpox rash.

The vaccine should not be given if the recipient is pregnant or plans to be in the 3 months afterwards.

Occasionally the weakened vaccine virus can be passed on to people with very poor immune systems, pregnancy or newborn babies. For this reason contact with this type of person should be avoided if possible for up to 6 weeks after vaccination.

**If you are not sure whether VARIVAX should be given, talk to your doctor, nurse or the Consultant at Direct Remedies.**

**Tell the doctor if:**

- You are breast-feeding. It is not known if VARIVAX passes into breast milk, however the vaccine is not expected to cause problems in breast-fed babies.
- If you have/your child has had VARIVAX before and became unwell, tell the consultant or nurse before the dose is given.
- You have or your child has had a blood or plasma transfusion in the last 5 months
- You have/your child has any medical conditions, such as:
  - a bleeding disorder. Sometimes VARIVAX may need to be given differently in people with bleeding problems.
  - an immune deficiency condition (e.g. are HIV positive).
- You have/your child has allergies to any other medicines or substances, such as dyes, foods or preservatives.
- You have/your child has received another vaccine. VARIVAX can be given at the same time as other vaccines.
- You are/your child is taking any prescription or OTC (over-the-counter) medicines or any medicine you have bought from a supermarket or health food shop.

## **Dosage Schedule.**

From the age of 12 months up to and including 12 years of age: 1 dose

From 13 years and up, 2 doses should be given, with an interval of at least 6 weeks between the first and second dose.

## **How and When Is It Given.**

VARIVAX will be injected into the upper arm muscle in most recipients. The injection is given subcutaneously (under the skin).

The vaccine should never be given intravenously (into a vein) or intradermally (into the skin).

VARIVAX is generally given as a single dose on an elected date. If a second dose is given, it will be administered 6 weeks after the first dose.

## **Things to be careful of**

If you develop the chicken pox blisters within the first 6 weeks after vaccination, avoid contact with people who are immune suppressed (have problems with their immune system) for the duration of the rash.

Be careful driving or operating machinery until you know how the vaccine affects you. It should not normally interfere with your ability to drive a car or operate machinery. But in some people vaccination can cause dizziness or light-headedness. Make sure you know how you react to VARILRIX before you drive a car or operate machinery, or do anything that could be dangerous if you are dizzy or light-headed.

## **Side Effects**

Tell the doctor or nurse as soon as possible if you (or your child) do not feel well during or after having had a dose of VARIVAX.

VARIVAX helps protect most people from varicella virus, but it may have unwanted side effects in a few people. All medicines and vaccines can have side effects. Sometimes they are serious; most of the time they are not. Some side effects may need medical treatment.

Most unwanted effects are mild and usually clear up within a few days. These effects, as with other vaccines, generally occur around the injection site such as tenderness, soreness and redness.

### **Mild effects**

- redness, swelling, a hard lump, soreness, bruising or itching around the injection site
- feeling generally unwell, fever, or headache
- loss of appetite, or feeling sick (nausea), vomiting, diarrhoea.

***Serious effects; As with all vaccines given by injection there is a very small risk of serious allergic reaction. Contact your doctor immediately or go to the Accident and Emergency department of your nearest hospital if any of the following happens:***

- swelling of limbs, face, eyes, inside of nose, mouth or throat
- shortness of breath, breathing or swallowing difficulties
- hives, itching (especially of the hands or feet), reddening of skin (especially around the ears), or severe skin reactions
- unusual tiredness or weakness that is sudden and severe, muscular aches and pains
- fever, headache, dizziness.

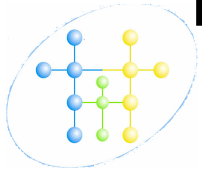
### **Other serious but rare side effects**

- brain inflammation (encephalitis)
- strokes, fits, Guillain-Barre syndrome
- Inflammation of the spinal cord
- Bells palsy
- Skin infection
- Chickenpox rash, shingles.

Do not be alarmed by this list of possible side effects. They are rare.

Author: Dr.D.D.Ratnasinghe.

Revised: November 2007



## Vaccination Registration From: 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.

January 2007

**Vaccination Registration Form: Clinic Copy**

(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?

\_\_\_\_\_

\_\_\_\_\_

**Vaccination Registration Form: Clinic Copy**

**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 \_\_\_

Manchester Clinic\_\_\_ Peterborough Clinic\_\_\_ Exeter 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.**

**Vaccination Registration Form: Clinic Copy**

**CLINIC USE ONLY**

Name of Client/Child: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**1<sup>st</sup> 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: \_\_\_\_\_

**2<sup>nd</sup> 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: \_\_\_\_\_