Child Vaccination Consent

Informed consent. The paediatrician fills the treatment details and explains them; the patient or their representative signs.

Clinic and clinician

HOSPITAL OR CLINIC

PAEDIATRICIAN NAME

REGISTRATION NO. (MEDICAL COUNCIL)

PATIENT ID / UHID

Patient

PATIENT FULL NAME

EMAIL

DATE OF BIRTH

GENDER

PHONE

Proposed treatment

VACCINE(S) DUE

DATE

BRAND AND BATCH NO.

NEXT DUE ON

The vaccines listed follow the schedule recommended for your child's age. Optional vaccines and their cost are discussed separately. Please bring the vaccination card.

Risks

Every treatment carries some risk. The common and the serious ones for this treatment include:

- Pain, swelling or a small lump where the injection was given
- Fever and irritability for a day or two
- Rarely, a febrile fit with some vaccines
- Severe allergic reaction (very rare)

RISKS SPECIFIC TO THIS PATIENT

Alternatives

- Delaying a dose if the child is unwell
- Declining a vaccine, with the risk of the disease

Your health

Is the child unwell or feverish today?

○ No ○ Yes

Did the child react badly to an earlier vaccine?

○ No ○ Yes

Does the child have a seizure disorder or immune problem?

○ No ○ Yes

ALLERGIES, CURRENT MEDICINES, OR DETAILS OF ANY "YES"

Consent

EXPLAINED TO ME IN

SIGNED BY

REPRESENTATIVE NAME (IF NOT PATIENT)

RELATIONSHIP

- The paediatrician has explained the treatment, its purpose, risks and alternatives in a language I understand, and answered my questions.
- I understand no result can be guaranteed.
- This consent covers only the treatment described. If an unexpected problem arises during it that puts life or health at immediate risk, the team may do what is needed to deal with it and will explain afterwards.
- I may withdraw this consent at any time before the treatment starts.

☐ I give my consent to the treatment described above.

Patient

SIGNATURE

PRINTED NAME

DATE

Paediatrician

SIGNATURE

PRINTED NAME

DATE