**Dr Miles & Valasapalli Medical Practice**

**My Child’s Immunisation History**

***Please write clearly and in BLOCK CAPITALS. (1 child per form)***

|  |  |
| --- | --- |
| **Childs Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Childs NHS No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Childs Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **GP Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Routine Childhood Immunisations** | **Age usually given** | | **Date Given (dd/mm/yy)** |
| **1st DTaP/IPV/HIB**  Diphtheria, tetanus, pertussis, polio, and Hib | 2 months  (8 Weeks) | |  |
| **Hepatitis B** |  |
| **MEN B**  Meningococcal B |  |
| **Rotavirus** |  |
| **PCV**  Pneumococcal (Part of UK schedule until 01.01.2020) |  | |  |
| **2nd** **DTaP/IPV/HIB**  Diphtheria, tetanus, pertussis, polio, and Hib | 3 months  (12 Weeks) | |  |
| **Hepatitis B** |  |
| **PCV**  Pneumococcal  **Rotavirus** |  |
|  |
| **3rd** **DTaP/IPV/HIB**  Diphtheria, tetanus, pertussis, polio, and Hib | 4 months  (16 Weeks) | |  |
| **Hepatitis B** |  |
| **MEN B**  Meningococcal B |  |
| **Hib/Men C** | 12 - 13 months | |  |
| **1s**t **MMR**  Measles, Mumps, Rubella |  |
| **PCV**  Pneumococcal Booster |  |
| **MEN B**  Meningococcal B Booster |  |
| **Pre School Booster 4th DTaP/IPV**  Diphtheria, tetanus, pertussis, polio Booster | 3yrs 4 months | |  |
| **2nd MMR**  Measles, Mumps, Rubella Booster | 3yrs 4 months | |  |
| **HPV 1**  Human Papillomavirus (Cervical Cancer) | 12-13 years | |  |
| **HPV 2**  Human Papillomavirus (Cervical Cancer) | 12-13 years | |  |
| **Td/IPV**  Tetanus, diphtheria, polio booster  **MenACWY**  Meningococcal A C W Y | 14 years (Year 9 school) | |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NoN Routine Vaccines** | **Date given**  **(DD/MM/YY)** | | **OTHER VACCINES RECEIVED** | | |
| BCG |  | |  | | |
| Meningitis C |  | |  | | |
| Chicken Pox (Varicella) |  | |  | | |
| Hib Booster (Haemophilus Influenza B) |  | |  | | |
| Hepatitis B | 1st | 2nd | 3rd | 4th |  |

**Please return this completed form to your GP surgery or take a photocopy/picture of your child’s schedule and email to the GP.**

**Are you following the UK Immunisation Schedule? YES / NO (Please circle)**

**If No, please state which country ……….…………………………………………………………..**

**Parents Name:**

**Date ..…..…/…..……/…….…..**