**Meir Park & Weston Coyney 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 ..…..…/…..……/…….…..**