BURNFIELD MEDICAL PRACTICE

Childs Name_____ **D.O.B** _____

As parent/guardian of the above named child, I (print name) _____ confirm that the following immunisations have been administered:

When to immunise	Diseases protected against	Date given (tick if unknown)
8 weeks	Dipheria, Tetanus and Pertussis (whooping cough) Polio, Hib, Hepatitis B Rotavirus Men B	
12 weeks	Dipheria, Tetanus and Pertussis (whooping cough) Polio, Hib, Hepatitis B Rotavirus PCV	
16 weeks	Dipheria, Tetanus and Pertussis (whooping cough) Polio, Hib, Hepatitis B Men B	
12-13 months	Hib, Men C PCV Measles, Mumps and Rubella Men B	
3 years 4 months	Dipheria, Tetanus and Pertussis (whooping cough) and Polio Measles, Mumps and Rubella	
11-13 years	HPV	
Above 11 years	Dipheria, Tetanus and Polio Men ACWY BCG if at high risk	

Signature _____ Date _____