PRINCES GARDENS SURGERY

2a High Street, Aldershot, Hampshire, GU11 1BJ

01252 332210 01252 312490 www.princesgardenssurgery.co.uk

Childhood Immunisation Disclaimer Form

To: Princes Gardens Surgery

I / We acknowledge that all children can be exposed to disease that can have serious, if not fatal consequences; for example, Measles, Mumps, Meningitis and Polio. The only way to protect children is by immunisation; this will also help to protect other people with whom the child may come into contact, such as those with weakened immune systems, newborn babies or the elderly.

I / We also acknowledge that immunisation is the safest and best defence against epidemics that can kill or disable both adults and children. I / We understand that vaccines work by making the body produce antibodies which are used to fight diseases without infecting the person with the disease.

I / We understand that the Department of Health (DoH) states that immunisation is an "important decision" and immunisations should not be administered if two adults with parental responsibility cannot reach an agreement. If one adult consents and the other disagrees, the immunisation should not be carried out unless both adults with parental responsibility can agree to the immunisation.[1]

Having read the above, I / we would like to advise the practice that I / we do not wish for my / our child to participate in the NHS childhood immunisation schedule.

I / We assume full responsibility for my / our decision and confirm that I / we have read and understand the above statement about the associated risks and benefits and the importance of childhood immunisations in reducing the risk of my / our child contracting serious, potentially fatal diseases. Please do not send me / us any further invitations for childhood immunisations.

I / We understand that my / our child can be restored to the vaccination schedule at any time by contacting the practice.

I confirm I have sole parental responsibility for my child and this is my decision ☐

We confirm we have joint parental responsibility and are in agreement about this decision ☐

Continued overleaf...

1 DoH Reference guide to consent for examination or treatment

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Child's Full Name	
Date of birth	

Adult with parental responsibility 1:

Name:_____

Address: _____

Postcode:_____

Date of birth:_____

Signature:_____

Date:_____

Adult with parental responsibility 2:

Name:_____

Address: _____

Postcode:_____

Date of birth:_____

Signature:_____

Date:_____

Please return this form to the practice as soon as possible.

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