HSC Health and Social Care

Immunisation Unscheduled Attendance Form

Northern Ireland Child Health System
CHS7 (January 2026)

Child's Surname: _____ Forenames: _____

Date of Birth: ____/____/____ Sex: _____

Address: _____

_____ Postcode: _____

H & C No: _____ School: _____

I have understood the information provided on the following immunisation(s)/test and I agree to receive* / I agree to the above- named child receiving* (* Delete as appropriate), at the appropriate times, protection against or testing for the following diseases:
**** Diphtheria - Whooping Cough (Pertussis) - Tetanus - Hib – Polio – Hepatitis B - Rotavirus - Meningococcal B - Pneumococcal Conjugate Vaccine (PCV) - Measles, Mumps & Rubella (MMR) - Measles, Mumps, Rubella & Varicella (MMRV) Meningococcal C– Tuberculosis (Mantoux testing and BCG if indicated) - Human Papillomavirus (HPV) - Flu - Meningococcal ACWY** (**Only delete those for which consent has been REFUSED)

Signature _____
(Person with parental responsibility for above child/Young person to receive immunisation(s)/test)

* Treatment Centre Details: Treatment Centre No ☐

Name and Address:

_____

*** If this is a change of treatment centre and future immunisations for this child are to be given at the above centre, enter 'X' here:** ☐

Tick the appropriate box(es) to indicate the treatment given at this attendance and enter all other information in the spaces provided.
* - enter the code representing the professional who administered the vaccine/test – GP / HV (Health Visitor) / TR (Treatment Room Nurse) / PN (Practice Nurse) / HP (Health Protection Service) / MW (Midwife) / PD (Paediatrician) / O (Other):

Vaccine	✓				Batch No	Manufacturer	Immuniser*	Site of Imm
	1st	2nd	3rd	4th				
DTaP/IPV/Hib/HepB								RL/LL/RA/LA
Rotavirus (oral)								ORAL
PCV								RL/LL/RA/LA
Meningococcal B								RL/LL/RA/LA
Hib/MenC								RL/LL/RA/LA
DTaP/IPV/Hib/HepB *								RL/LL/RA/LA
MMRV **								RL/LL/RA/LA
MMR								RL/LL/RA/LA
PCV Booster								RL/LL/RA/LA
Meningococcal B Booster								RL/LL/RA/LA
Pre-school dTaP/IPV								RL/LL/RA/LA
School leaving Td/IPV								RL/LL/RA/LA
Meningococcal ACWY								RL/LL/RA/LA

Other	✓	Batch No	Manufacturer	Immuniser*	Site of Imm	Date & time of Mantoux	Date & time of reading	Mantoux reading (mm)
Flu- intranasal								
Flu – Injected					RL/LL/RA/LA			
Mantoux test					RL/LL/RA/LA			
Repeat Mantoux test					RL/LL/RA/LA			
BCG						Comments:		
Other					RL/LL/RA/LA			
HPV Dose 1					RL/LL/RA/LA			

Signature of Immuniser: _____

Signature of Doctor_____

GP Cypher No: _____

Date Immunisation(s) Given____/

Notes:1. Completed forms should be returned immediately to your local CH Office.
2. This form should only be used for children under 19 years of age (unless otherwise directed)
* Children born on or before 30th June 2024 should be offered hexavalent vaccine instead of Menitorix® when the national supply is exhausted and if the child is late for their one-year vaccine alongside their PCV13, MenB and 1st MMRV.

For **MMRV eligibility please see - The complete routine immunisation schedule from 1 January 2026 for healthcare professionals | HSC Public Health Agency

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