2026

CHS 7 -Immunisation Unscheduled Attendance Form

NOVEMBER 2026 UPDATE

Please note changes to the CHS7. Key points to note:

- Reference to **DOSE** (1st, 2nd, 3rd, 4th) administered in table
- Inclusions update due to revised childhood schedule
- Please review before completing and submitting to Child Health System promptly
- Update approved by Child Health System and PHA RUAG board
- Please disregard any previous versions

Please note links available within the PHA website are live documents, documents will be added and updated as they become available. Please use the online version of these documents and check regularly for updates.

HSC Health and Social Care

Immunisation Unscheduled Attendance Form

Northern Ireland Child Health System
CHS7 (November 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	DOSE ✓				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
MMRV *								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
MMR								RL/LL/RA/LA
HPV								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					RL/LL/RA/LA	Comments:		
Other					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)

*For **MMRV** eligibility please see - https://www.publichealth.hscni.net/publications/complete-routine-immunisation-schedule-1-january-2026-healthcare-professionals