

For In Office Use Appointment Date: _____ Appointment Time: _____ By Phone or In Person
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Vaccine Consult Consent Form

Childhood vaccinations has become a complicated multifaceted health issue. More and more parents are taking it upon themselves to research childhood vaccinations. Much of the information that is currently available about vaccines is written from a very polarized perspective. Vaccine advocates quote research studies and statistics that support their view as do anti-vaccine parties. Vaccination issues quickly become confusing and overwhelming to even a seasoned researcher. The purpose of this vaccination consultation is to help people make informed decisions about childhood vaccinations by providing them with reliable, up to date and relevant information as well as resources to further their own research.

Please indicate what you would like to discuss:

- Current childhood vaccination schedule
- Vaccination preventable infections (how serious are they, how often do they occur, etc.)
- Safety and efficacy of vaccines
- Vaccination options (modifying, postponing or refusing vaccines)
- Minimizing your child's risks (with or without vaccines)
- Additional questions or concerns: _____

Are there specific vaccines you would like to discuss? _____ If yes, please list: _____

Who were you referred by? _____

In order to ensure continuity of care, Dr. Bailetti provides referring doctors with a report regarding your vaccination consultation. Do you give Dr. Bailetti permission to do this? _____

I understand and agree to the following:

- The information in this session is intended as a supplement to information provided by your primary health care provider, not as a substitute.
- The information is not intended to cover all aspects of every vaccination issue.
- The vaccination sessions do not include individual naturopathic treatment information.
- Katia Bailetti assumes no responsibility from any effects associated with making decisions about vaccinations based on this information.
- The information provided and any recordings of the sessions are for personal use only.
- I agree to pay the full fee at the completion of the session. Appointments that are cancelled without 24 hour notice or more than 2 weeks overdue are subject to a \$50 fee. Cash, credit card, cheque and online Paypal payments are accepted.

Name of parent: _____ DOB (dd/mm/yy): _____

Name and ages of child(ren): _____

Address: _____ Phone number: _____

_____ Email: _____

Signature: _____ Date (dd/mm/yy): _____

Witness signature: _____ Date (dd/mm/yy): _____

Would you rather an appointment in clinic or by phone? _____

Please sign and fax this page to 647 436 9449 (or scan and email to admin@drbailetti.com) at your earliest convenience.