

Vaccine Consult and Support

2-hour Vaccination Consult and Support visit includes:

- Discussion of your questions and concerns regarding childhood vaccinations in an open and non-judgmental manner
- Handouts to help you make informed decisions regarding childhood vaccinations
- Specific natural treatments that support the body during vaccination (should you decide to vaccinate) or in place of vaccines (should you decide not to vaccinate)
- Review of your child's medical history
- A physical exam
- Ability to schedule 15-60 minute follow-up sessions (including telephone consultations) with Katia Bailetti to address future health concerns. Sessions vary in price from \$40 up.
- A Naturopathic invoice to submit to your health insurance provider.

The fee for the 2-hour Vaccination Consultation and Support session is \$200 +GST for an in-clinic visit. Appointments that are cancelled with less than 24 hours notice are subject to a 50\$ fee. Payments accepted include cash, cheque and online via Paypal.

Please complete all forms below prior to the session. I look forward to speaking with you soon.

Sincerely,

Katia Bailetti BSc, EMA, ND
Natural Child Health Care
Vaccination Information and Support
www.drbailetti.com
info@drbailetti.com

Your Child's Medical History

Name:	Age:	DOB (dd/mm/yy): / /	Gender:
Home phone:() -			
Address:		City:	Postal code:
Child lives with:		Number of children in home:	
Person filling out form:		Relation:	
Emergency contact:		Relation:	
Home phone:() -	Work:() -		
Medical doctor:			
Phone:() -	Fax:() -		
Address:		City:	Postal code:
Other health care provider:			Phone:() -
Address:		City:	Postal code:

Does your child get an annual:					
physical exam	<input type="checkbox"/> yes	<input type="checkbox"/> no	dental exam	<input type="checkbox"/> yes	<input type="checkbox"/> no
urine analysis	<input type="checkbox"/> yes	<input type="checkbox"/> no	eye exam	<input type="checkbox"/> yes	<input type="checkbox"/> no
Is your child's family medical history known: <input type="checkbox"/> yes <input type="checkbox"/> no			Adopted: <input type="checkbox"/> yes <input type="checkbox"/> no		

Please complete all relevant information. Answer to the best of your knowledge and we will discuss the details together during your appointment.

Main health concerns in order of importance:

Concern	Since (mm/yy)	Cause(s)
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Medical conditions your child has been diagnosed with:

Diagnosis	Date (mm/yy)	Current symptoms

Medications your child has taken in the past:

Medication	Dosage	Since (mm/yy)	Effects	Helpful	Well tolerated
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n

Medications your child is currently taking (including over the counter):

Medication	Dosage	Since (mm/yy)	Effects	Helpful	Well tolerated
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n

Any allergies or adverse reactions to medications? no yes Specify:
 Number of times your child has taken antibiotics in their life: In the past 5 years:

Supplements, remedies, herbs or other treatments your child is currently using:

Medication	Dosage	Since (mm/yy)	Effects	Helpful	Well tolerated
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n

Which of the following conditions has your child had?

<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Parasites	<input type="checkbox"/> Strep throat
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Herpes	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Malaria	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Measles	<input type="checkbox"/> Rubella	<input type="checkbox"/> Yellow fever
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mono	<input type="checkbox"/> Scarlet fever	
		<input type="checkbox"/> Mumps	<input type="checkbox"/> Sexual abuse	

Any other conditions? :
 Any conditions your child has never completely recovered from or which have been severe?

Operations, serious injuries or hospitalizations:

Incident	Date (mm/yy)	Complications or long term effects

Which of the following vaccinations has your child received?

<input type="checkbox"/> MMR (measles, mumps, rubella)	<input type="checkbox"/> Varicella	<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> DTP/DTaP (Diphtheria, typhoid, pertussis)	<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Influenza (flu)
<input type="checkbox"/> Hib (Haemophilus influenza)	<input type="checkbox"/> Meningococcal	<input type="checkbox"/> Small pox
<input type="checkbox"/> IPV (Polio)	<input type="checkbox"/> Varicella (chicken pox)	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Typhoid

Any other vaccines or boosters?

Any symptoms following a vaccination (rash, neurological problems...)?

no yes If yes, please describe:

Typical foods you eat during the course of the day

Breakfast	Lunch	Dinner	Snacks	Beverages (include amount)

Eating habits (picky, good appetite, etc...):

What foods were introduced before 6 months (include month introduced):

What foods were introduced between 6-12 months (include month introduced):

Breast fed? yes no Until what age:

Bottle fed? yes no Starting at what age:

Formula used: yes no Type:

Any colic? yes no For how long?

When introduced:
How severe?

Any food allergies or intolerances?

no yes If yes, please describe:

Any food cravings?

Often eat on the run? yes no Eat the same foods every day yes no

Any dietary restrictions (vegetarian, vegan, religious...)?

no yes If yes, please specify:

Specify any known conditions which have affected the following relatives:

Relative	Age if alive	Age at death	Condition(s)
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Maternal Aunts/Uncles			
Paternal Aunts/Uncles			

Perinatal Information

Mother's health at conception:	During pregnancy:
Mother's nutrition during pregnancy:	Nutrition while breastfeeding:
Mother's age at child's birth:	Father's health at conception:
Any fertility issues: <input type="checkbox"/> no <input type="checkbox"/> yes	Specify:
Prenatal care by:	Location of birth:
Term length:	Length of labour:

Any of the following medical procedures used during the pregnancy or delivery:

<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Triple screen	<input type="checkbox"/> Epidural/anesthesia
<input type="checkbox"/> Amniocentesis	<input type="checkbox"/> Maternal serum testing	<input type="checkbox"/> Episiotomy
<input type="checkbox"/> Chorionic villi sampling	<input type="checkbox"/> Induced labour	<input type="checkbox"/> C-section
	<input type="checkbox"/> Use of forceps	<input type="checkbox"/> Other:

Any of the following experienced during the pregnancy or shortly after birth?

<input type="checkbox"/> Bleeding during pregnancy	<input type="checkbox"/> Nausea	<input type="checkbox"/> Infection
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Difficulty breastfeeding
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Physical or emotional trauma
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Post partum depression
		<input type="checkbox"/> Other:

Any of the following medical procedures after birth?

<input type="checkbox"/> Vitamin K injection	<input type="checkbox"/> PKU test (heel prick)	<input type="checkbox"/> Eye antibiotics
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Any of the following experienced by your child after birth:

<input type="checkbox"/> Low APGAR score	<input type="checkbox"/> Birth injuries	<input type="checkbox"/> Birth defects
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Birth complications	<input type="checkbox"/> Inadequate weight gain
<input type="checkbox"/> Rashes	<input type="checkbox"/> Infections	<input type="checkbox"/> Fever
<input type="checkbox"/> Seizures	<input type="checkbox"/> Difficulties with feeding	<input type="checkbox"/> Other:

Select 'Y' (yes) for symptoms you are presently experiencing (includes last 2 months).
 Select 'P' (past) for symptoms experienced in the past. It is possible to check both 'Y' and 'P'.

GENERAL Height Weight Maximum weight Birth weight Recent weight change <input type="checkbox"/> Y <input type="checkbox"/> P Recent international travel <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P		EYES Glasses or contacts <input type="checkbox"/> Y <input type="checkbox"/> P Vision deteriorating <input type="checkbox"/> Y <input type="checkbox"/> P Blurring <input type="checkbox"/> Y <input type="checkbox"/> P Blind spot <input type="checkbox"/> Y <input type="checkbox"/> P Sun irritates <input type="checkbox"/> Y <input type="checkbox"/> P Discharge <input type="checkbox"/> Y <input type="checkbox"/> P Dryness <input type="checkbox"/> Y <input type="checkbox"/> P Infections <input type="checkbox"/> Y <input type="checkbox"/> P Itching <input type="checkbox"/> Y <input type="checkbox"/> P Pain <input type="checkbox"/> Y <input type="checkbox"/> P Puffy eyes <input type="checkbox"/> Y <input type="checkbox"/> P Redness <input type="checkbox"/> Y <input type="checkbox"/> P Tearing <input type="checkbox"/> Y <input type="checkbox"/> P Styes <input type="checkbox"/> Y <input type="checkbox"/> P Dark circles <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P		NECK Pain or stiffness <input type="checkbox"/> Y <input type="checkbox"/> P Lumps <input type="checkbox"/> Y <input type="checkbox"/> P Swollen glands <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P RESPIRATORY Shortness of breath <input type="checkbox"/> Y <input type="checkbox"/> P Pain on breathing <input type="checkbox"/> Y <input type="checkbox"/> P Chronic cough <input type="checkbox"/> Y <input type="checkbox"/> P Sputum <input type="checkbox"/> Y <input type="checkbox"/> P Wheezing <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P	
SKIN Acne <input type="checkbox"/> Y <input type="checkbox"/> P Bumps or lumps <input type="checkbox"/> Y <input type="checkbox"/> P Warts <input type="checkbox"/> Y <input type="checkbox"/> P Eczema <input type="checkbox"/> Y <input type="checkbox"/> P Psoriasis <input type="checkbox"/> Y <input type="checkbox"/> P Hives <input type="checkbox"/> Y <input type="checkbox"/> P Rashes <input type="checkbox"/> Y <input type="checkbox"/> P Itching <input type="checkbox"/> Y <input type="checkbox"/> P Dry skin <input type="checkbox"/> Y <input type="checkbox"/> P Slow wound healing <input type="checkbox"/> Y <input type="checkbox"/> P Perspiration at night <input type="checkbox"/> Y <input type="checkbox"/> P Odor to perspiration <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P		NOSE & SINUSES Decreased smell <input type="checkbox"/> Y <input type="checkbox"/> P Stuffy or runny <input type="checkbox"/> Y <input type="checkbox"/> P Allergies <input type="checkbox"/> Y <input type="checkbox"/> P Sinus problems <input type="checkbox"/> Y <input type="checkbox"/> P Bleeding <input type="checkbox"/> Y <input type="checkbox"/> P Polyps <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P		CARDIOVASCULAR Murmurs <input type="checkbox"/> Y <input type="checkbox"/> P Palpitations <input type="checkbox"/> Y <input type="checkbox"/> P Red face, flush easy <input type="checkbox"/> Y <input type="checkbox"/> P Cold hands and feet <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P	
NAILS Bend or break easily <input type="checkbox"/> Y <input type="checkbox"/> P White spots <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P		MOUTH & THROAT Decreased taste <input type="checkbox"/> Y <input type="checkbox"/> P Bad breath <input type="checkbox"/> Y <input type="checkbox"/> P Mouth dryness <input type="checkbox"/> Y <input type="checkbox"/> P Canker sores <input type="checkbox"/> Y <input type="checkbox"/> P Cold sores <input type="checkbox"/> Y <input type="checkbox"/> P Toothache <input type="checkbox"/> Y <input type="checkbox"/> P Gum bleeding <input type="checkbox"/> Y <input type="checkbox"/> P Frequent sore throat <input type="checkbox"/> Y <input type="checkbox"/> P Hoarseness <input type="checkbox"/> Y <input type="checkbox"/> P Lump in throat <input type="checkbox"/> Y <input type="checkbox"/> P		BLOOD & LYMPH Frequently ill <input type="checkbox"/> Y <input type="checkbox"/> P Bleed or bruise easily <input type="checkbox"/> Y <input type="checkbox"/> P Clotting problem <input type="checkbox"/> Y <input type="checkbox"/> P Lymph node swelling <input type="checkbox"/> Y <input type="checkbox"/> P	
HEAD Dizziness <input type="checkbox"/> Y <input type="checkbox"/> P Headaches <input type="checkbox"/> Y <input type="checkbox"/> P Migraines <input type="checkbox"/> Y <input type="checkbox"/> P Injuries <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P		Number of metal fillings Other: <input type="checkbox"/> Y <input type="checkbox"/> P		MUSCULO / SKELETAL Muscle cramps <input type="checkbox"/> Y <input type="checkbox"/> P Muscle weakness <input type="checkbox"/> Y <input type="checkbox"/> P Joint pain or stiffness <input type="checkbox"/> Y <input type="checkbox"/> P Joints pop often <input type="checkbox"/> Y <input type="checkbox"/> P Joint swelling <input type="checkbox"/> Y <input type="checkbox"/> P Back pain <input type="checkbox"/> Y <input type="checkbox"/> P Broken bones <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P	
EARS Decreased hearing <input type="checkbox"/> Y <input type="checkbox"/> P Excess wax <input type="checkbox"/> Y <input type="checkbox"/> P Infections <input type="checkbox"/> Y <input type="checkbox"/> P Discharge <input type="checkbox"/> Y <input type="checkbox"/> P Itching <input type="checkbox"/> Y <input type="checkbox"/> P Pain <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P					

<p>NEUROLOGICAL</p> <p>Convulsions <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Fainting <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Involuntary movement <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Loss of balance <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Numbness or tingling <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Paralysis <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Speech problems <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Other: <input type="checkbox"/>Y<input type="checkbox"/>P</p>		<p>URINARY</p> <p>Bedwetting <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Infections <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Inability to hold urine <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Increased urination <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Pain on urination <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Blood in urine <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Cloudy urine <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Dark urine <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Other: <input type="checkbox"/>Y<input type="checkbox"/>P</p>		<p>MENTAL & EMOTIONAL</p> <p>Anxiety <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Depression <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Fatigue <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Difficulty concentration <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Mood swings <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Phobias <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Other: <input type="checkbox"/>Y<input type="checkbox"/>P</p>	
<p>GASTROINTESTINAL</p> <p>Bowel movements how often? <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Constipation <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Diarrhea <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Rectal bleeding <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Rectal itching <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Undigested food in stool <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Blood in stool <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Mucous in stool <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Change in thirst <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Change in appetite <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Low blood sugar <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Pain in abdomen <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Hernias <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Burping <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Flatulence <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Bloating <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Nausea <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Vomiting <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Difficulty swallowing <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Other: <input type="checkbox"/>Y<input type="checkbox"/>P</p>		<p>FEMALE ONLY</p> <p>Vaginal discharge <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Vaginal itching <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Other: <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>MALE ONLY</p> <p>Undescended testicles <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Testicular mass <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Difficult urination <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Other: <input type="checkbox"/>Y<input type="checkbox"/>P</p>			

Naturopathic Visit Consent Form

I voluntarily consent to the procedures and treatments on behalf my child _____ by Naturopathic Doctor Katia Bailetti, which can include any combination of the following: medical history, physical exam, diagnostic testing, botanical medicine, homeopathy, traditional Chinese medicine, clinical nutrition, hydrotherapy, lifestyle counselling and coaching, physical therapies and mind-body medicine.

I understand the following:

- My child's medical records will be kept confidential and will not be released to anyone without my consent, unless required by law or I am at risk of harming myself or others. In order to ensure optimal care, Naturopathic Doctors may consult with other professionals about my case..
- Naturopathic medicine can be used to help prevent and treat illnesses. However, Naturopathic Doctors cannot guarantee results of treatment.
- Complications are very rare when treated by a licensed Naturopathic Doctor. Naturopathic Doctors cannot anticipate all risks and complications associated with treatment; however, they will do their best to inform me of the most common side-effects.
- I am responsible for informing the above Naturopathic Doctor if my child's condition or medications change, as treatments may be contraindicated in some conditions.
- I agree to pay for charges incurred during each visit by the end of the visit. I will be provided with a receipt upon payment so that I can bill my insurance company. I will be charged additional fees for laboratory testing as well as supplements/homeopathic remedies/herbal medicines. I will also be charged a \$50 fee for missed appointments, late cancellations (less than 24 hours) and overdue payments, (including bounced cheques).
- Katia Bailetti will endeavor to collect and maintain accurate personal information about me and my child for the purpose of assessing my health concerns, advising me of my options, providing high quality natural and professional healthcare, maintaining contact with me and my child, facilitating practice management and complying with naturopathic regulations.

Patient's name: _____

DOB (dd/mm/yy): _____

Guardian's name: _____

Relation: _____

Guardian's signature: _____

Date (dd/mm/yy): _____

Witness signature: _____

Date (dd/mm/yy): _____

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)

Do you have additional questions or concerns about vaccines?

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

Who were you referred by? _____

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.
- 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 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): _____

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