Flu immunisation consent form

Parent / Guardian to complete

ALL SECTIONS OF THIS FORM MUST BE COMPLETED

INCOMPLETE DETAILS MAY RESULT IN YOUR CHILD NOT BEING VACCINATED

Student Details		
First Name:	Surname:	
Date of Birth:	Gender: **Girl** ☐ **BOY** ☐	School & Class:
NHS Number:	Home Telephone:	**GP Name & Address:**
Home Address: Postcode:	Parent/Guardian Mobile:	

Has your child been diagnosed with asthma?
YES ☐ **NO** ☐

If **YES**, and your child is currently taking inhaled steroids (i.e. uses a preventer or regular inhaler), please enter the medication name and daily dose (e.g. Budesonide 100 micrograms, four puffs per day):

If **YES,** and your child has taken steroid tablets because of their asthma in the past two weeks please enter the name, dose and length of course:

PLEASE LET THE IMMUNISATION TEAM KNOW IF YOUR CHILD HAS TO INCREASE HIS OR HER ASTHMA MEDICATION AFTER YOU HAVE RETURNED THIS FORM

Has your child had a flu vaccination in the last 6 months
YES ☐ **NO** ☐

Does your child have a disease or treatment that severely affects their immune system (e.g. treatment for leukaemia)
YES ☐ **NO** ☐

Is anyone in your family currently having treatment that severely affects their immune system? (e.g. they need to be kept in isolation)
YES ☐ **NO** ☐

Does your child have a severe egg allergy? (needing hospital care)
YES ☐ **NO** ☐

Does your child have any other allergies?
YES ☐ **NO** ☐
For example gentamicin, gelatine or any other allergies, please list:
……

Is your child receiving salicylate therapy?
(i.e. aspirin) **YES** ☐ **NO** ☐

Does your child have any medical conditions please give details:
YES ☐ **NO** ☐
*If you answered **YES** to any of the above, please give details:
……

ON THE DAY OF VACCINATION, PLEASE LET THE IMMUNISATION TEAM KNOW IF YOUR CHILD HAS BEEN WHEEZY IN THE PAST THREE DAYS.

N.B The nasal flu vaccine contains products derived from pigs (porcine gelatine). If the vaccine is refused due to this content, only children who are at high risk from flu due to a medical condition will be offered an alternative injected vaccine. More information is available from www.nhs.uk/child-flu-FAQ

CONSENT FOR IMMUNISATION

YES, I CONSENT

to my child receiving the flu immunisation

Signature: ……
(Parent/guardian with parental responsibility)
Print name: ……
(parent/guardian)
Date: ……

NO, I DO NOT CONSENT

to my child receiving the flu immunisation

Signature: ……
(Parent/guardian with parental responsibility)
Print name: ……
(parent/guardian)
Date: ……

FOR OFFICE USE ONLY

Eligibility assessment on day of vaccination:

Has the parent/child reported being wheezy over the past three days **YES** ☐ **NO** ☐

If the child has asthma, has the parent/child reported:

- Use of oral steroids in the past 14 days? **YES** ☐ **NO** ☐
- An increase in inhaled steroids since consent form completed

Pre-vaccination assessment for flu completed

Child not immunised today because:

- **Not well today**
- **Allergies**
- **Asthma**
- **Refused (none given)**
- **Refused (partially given)**

Child suitable for immunisation: YES / NO Nurse's signature: ……..

VACCINE: **ASTRA ZENEKA FLUENZ TETRA NASAL SPRAY**	**DATE GIVEN:**
BATCH NUMBER:	**EXPIRY DATE:**
IMMUNISER (PRINT NAME):	