**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:  Parent/Guardian Mobile: | | | | **GP Name & Address:** |
| Home Address:  Postcode: |
|  | | | | | |
| 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):** | |