CityCare
Building Healthier Communities

NHS

NASAL FLU IMMUNISATION CONSENT FORM

Important information: The nasal influenza vaccine is being offered to your child and is to be given at their school. Please ensure that you have read the accompanying leaflet before completing the form. Your Doctor's surgery will be sent details of your child's vaccination so that this information can be entered in their health record.

PARENT/GUARDIAN TO COMPLETE USING CAPITAL LETTERS AND BLUE OR BLACK INK

Pupil details			
Child's first and last name:			
Date of birth:		GP Practice:	
Gender: Girl ☐ Boy ☐	**School:**		Year group:
NHS Number:		We may wish to contact you to discuss any queries. Please provide your contact telephone number(s) below:	
Home address:		Ethnicity:	

Has your child had a severe reaction to a previous immunisation?	Yes ☐	No ☐
Does your child suffer with any medical conditions? (e.g. heart, diabetes)	Yes ☐	No ☐
Is your child currently having treatment that severely weakens their immune system? (e.g. they are receiving treatment for leukaemia or cancer)	Yes ☐	No ☐
Does your child have contact with anyone who is having treatment that severely weakens their immune system and requires isolation (e.g. bone marrow transplant?)	Yes ☐	No ☐
Does your child have any allergies? (e.g. eggs, gentamicin)	Yes ☐	No ☐
Is your child receiving salicylate therapy? (aspirin)	Yes ☐	No ☐
If you answered Yes to any of the above, please give details *(what medical conditions/allergies/reactions):*		
Has your child been **diagnosed** with asthma? If Yes* please complete the table below:	Yes* ☐	No ☐

Name of medication/inhaler	Strength	How often is it required?
eg clenil modulite	*eg 50 mcg*	*eg 1 puff twice a day*

Has your child received a flu vaccination before?	Yes ☐	No ☐

Consent for immunisation (please tick YES or NO)
PLEASE BE AWARE THAT PORK GELATINE IS USED IN THE MANUFACTURING OF THE VACCINE
Please refer to the enclosed leaflet for further information or visit www.nhs.uk/child-flu

YES ☐ I consent for my child to receive the flu immunisation	**NO** ☐ I do not consent for my child to receive the flu immunisation
Name and signature of parent/guardian (with parental responsibility): Name..... Signature..... Date.....	Please give reason: Name and signature of parent/guardian (with parental responsibility): Name..... Signature..... Date.....

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IMMUNISATION NURSE USE ONLY

SystmOne check to clarify vaccination status of children with asthma: *Date/Initial*	
Requires 2 doses (applicable to under 9 years old only) and phone call to parent/guardian to clarify consent :	☐
Verbal consent obtained by: Signature..... Date..... Witness.....	
Eligibility assessment on day of vaccination Has the parent/child reported the child being wheezy over the past seven days?	Yes ☐ No ☐

Vaccine details

	Name of vaccine	Batch Number	Expiry date	Immunising Nurse	Date
First dose					
Second dose (if required)					

IMMUNISATION ATTENDANCE RECORD / COMMENTS: