FLU NASAL IMMUNISATION CONSENT FORM

Name of Child _____ **Date of Birth** _____

Any Previous Surname(s) _____ **Boy** ☐ **Girl** ☐

Address _____

_____ **Tel No** _____

School/Education Centre _____ **Year Group**_____

Name of GP Practice _____

Important information about this immunisation which is given as a nasal spray

Does your child normally have his or her flu vaccination at your GP surgery ***(if Yes continue to go to GP)***	Yes/No
Has your child had a severe (anaphylactic) allergic reaction to any previous vaccines	Yes/No
Is your child receiving salicylate therapy (e.g. aspirin) Yes/No	
Does your child have a confirmed anaphylaxis to egg or an egg allergy	Yes/No
Is your child on any other regular medication If 'yes' please provide details	Yes/No
Has your child had an any vaccinations in the last four weeks or are they due one soon (If yes please give details)	Yes/No
Does your child have asthma	Yes/No
If YES please tick level of their disease Mild ☐ Moderate ☐ Severe ☐	
Has your child got a condition or are they receiving treatment that makes them Immunosuppressed	Yes/No
Is anyone in your family currently having treatment that severely affects their immune system *(for example they need to be kept in special isolation?)*	Yes/No

Please sign here so that we can include your child in our immunisation programme.

- I would like my child to have the **flu nasal** immunisation.

Signed ……

Date ……

Please tick the box to confirm you are the parent or have parental responsibility (see overleaf for more details) ☐

If you <u>do not</u> want us to include your child in the immunisation programme, please sign below.

- <u>I do not want my child</u> to have the nasal flu immunisation

Signed ……
(*Signature of person with parental responsibility*)

Date ……

PLEASE RETURN THIS FORM TO SCHOOL

Parental Responsibility

Mother
Father – if named on birth certificate after 2003 or married to mother at time of birth.
Father has parental responsibility order from Court
Other person that has been granted Residence Order by Court
Any questions, please contact us on 01502 527591.

FOR STAFF USE ONLY

CONTRAINDICATION ASSESSMENT

CLIENT PYREXIAL OR SYSTEMICALLY UNWELL, NOT MINOR INFECTION (DEFER)

Immunisation Comments:……..……

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HISTORY OF ANAPHYLAXIS TO A PREVIOUS VACCINE **YES/NO**

ANY ALLERGIES **YES/NO**

ANY POSSIBILITY OF PREGNANCY **YES/NO**

Vaccination given by …… **Date** ……

Batch details: **Time** ……

Make:

Number:

Expiry Date: