

NASAL FLU IMMUNISATION CONSENT FORM
THIS VACCINE CONTAINS PORCINE GELATIN

Child's full name (first name and surname):	Date of birth: ____/____/____	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Home address:	Daytime telephone number for parent /carer:	
	Ethnicity:	
School:	Year group/class:	
GP name and address:	NHS number (if known):	

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS

1. Has your child been diagnosed with asthma?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Does your child have a severe egg allergy that has resulted in the need for hospital treatment?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Is your child or any of your family currently having treatment that severely affects their immune system e.g. chemotherapy, malignancy, HIV? If yes, please give details overleaf.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. Is your child receiving salicylate therapy i.e. Aspirin?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5. Do you agree to inform the immunisation team if your child receives the flu immunisation elsewhere (eg.at your GP) this year, from September 2020?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

CONSENT FOR THE NASAL FLU IMMUNISATION, PLEASE COMPLETE ONE BOX BELOW
CONSENT
Yes - I would like my child to receive the nasal flu vaccination

Parent/Carer Name:

Relationship to child:

Signature

(Parent/Legal Guardian)

Date ____/____/____

NON CONSENT
No - I do not want my child to have the nasal flu vaccination

Parent/Carer Name:

Relationship to child:

Signature

(Parent/Legal Guardian)

Date ____/____/____

Prior to the day of immunisation please let the team know if your child has been wheezy or has needed an increase in their asthma medication in the previous three days

OFFICE USE ONLY

Date of nasal flu vaccination ____/____/____	Batch number/ expiry date	Immuniser (please print)	Where administered (school, college, GP etc)
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DETAILS OF TREATMENT CURRENTLY BEING GIVEN TO CHILD OR FAMILY MEMBER - TO BE COMPLETED BY PARENT / GUARDIAN

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OFFICE USE ONLY

Eligibility checked by	Signed	Date ____/____/____
Date of attempted vaccination ____/____/____	Reason vaccination not given	
Date ____/____/____	Post immunisation issues / adverse reactions / notes	