Flu Immunisation Consent Form

Parent/Guardian/Carer to complete

Please return this completed form to your child's school by (date) _____

Student details

Surname:	Forename(s):	DOB:
NHS no *(if known)*:	Gender: Girl ☐ Boy ☐	Family doctor's name:
Address and postcode:	School name:	Doctor's address and postcode:
Phone number of parent/guardian/carer:	Class/Form:	Doctor's phone number:

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

Has your child had a severe *(anaphylactic)* allergic reaction to any previous vaccines? Yes ☐ No ☐ If 'yes' please provide details	Has your child got a condition or are they receiving treatment that makes them immunosuppressed? Yes ☐ No ☐ If 'yes' please provide details	Is your child receiving salicylate therapy *(i.e. aspirin)*? Yes ☐ No ☐ If 'yes' please provide details
Does your child have a confirmed egg allergy? Yes ☐ No ☐		Does your child normally have his or her flu vaccination at your GP's surgery? Yes ☐ No ☐
Does your child have asthma? Yes ☐ No ☐ If YES, please tick level of their disease Mild ☐ Moderate ☐ Severe ☐ and record the **daily** medication they take:	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 ☐ If 'yes' please provide details	Is your child on any other regular medication? Yes ☐ No ☐ If 'yes' please provide details
Has your child had an MMR vaccination in the last four weeks or are they due one soon? Yes ☐ No ☐		Would you be happy to be contacted to find out what you thought about the service? Yes ☐ No ☐

Consent for immunisation for my son/daughter to receive the flu nasal spray

I have read and understood the information about the **flu nasal spray** ☐	Date:
YES, I CONSENT ☐	**NO, I DO NOT CONSENT** ☐ (Please give reasons on the back of this form.)
Do you consent to share information about your child's immunisation with your GP, NHS and related organisations? Yes ☐ No ☐	
Name:	Signature of parent/guardian/carer:

OFFICE USE ONLY

Pre-vaccination assessment for flu completed ☐ Child not immunised today because: Not well enough today ☐ Allergies ☐ Asthma ☐ Refused *(none given)* ☐ Refused *(partially given)* ☐ Child suitable for immunisation: Signature:	**FLUENZ vaccine details** Date given: Batch number: Expiry date: Vaccination administered by *(print name)*: Signature: