

**Important information:** Please read the accompanying patient information leaflet and the notes section on the letter before completing this form. **ONLY ONE CHILD PER FORM.**

Child's Surname:		NHS Number:	
Child's First Name:		Home Address:	
Child's Date of Birth:	Age:		
Name of School:			
School year:	Class:	Postcode:	
GP surgery:		Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	

We may wish to contact you to discuss any queries and for feedback. Please provide your contact details.

Mobile number:	Home number:
Email address:	

1. Has your child been diagnosed with Asthma?	<input type="checkbox"/> <b>Yes</b> <i>If yes, and your child is currently using a preventer or regular inhaler please enter the medication name and daily dose (e.g Budesonide 100 micrograms, four puffs per day)</i> <input type="checkbox"/> <b>No</b>
<i>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.</i>	
2. Has your child already had a flu vaccination in the last 4 months?	<input type="checkbox"/> <b>Yes</b> <i>If yes, when?</i> <input type="checkbox"/> <b>No</b>
3. Has your child had a bad reaction to any previous flu vaccine or to an antibiotic called gentamicin?	<input type="checkbox"/> <b>Yes</b> <i>If yes please give details</i> <input type="checkbox"/> <b>No</b>
4. Does your child have a severe allergy to eggs, which has been confirmed by a specialist doctor?	<input type="checkbox"/> <b>Yes</b> <i>If yes please give details</i> <input type="checkbox"/> <b>No</b>
5. Is your child receiving oral salicylate therapy (i.e. Aspirin)	<input type="checkbox"/> <b>Yes</b> <i>If yes please give details</i> <input type="checkbox"/> <b>No</b>
6. Has your child got a health condition that severely weakens their immune system (e.g. receiving treatment for leukaemia)?	<input type="checkbox"/> <b>Yes</b> <i>If yes please give details</i> <input type="checkbox"/> <b>No</b>
7. Is anyone in your family currently having treatment that severely weakens their immune system (e.g. bone marrow transplant recipient requiring isolation or chemotherapy)?	<i>If yes please give details</i> <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <i>Can you child avoid close contact with them for two weeks after receiving the vaccine?</i> <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
8. Has your child been diagnosed with a bleeding disorder?	<input type="checkbox"/> <b>Yes</b> <i>If yes please give details</i> <input type="checkbox"/> <b>No</b>

**Consent Declaration (complete only ONE part below)**

NB: The nasal flu vaccine contains products derived from pigs (porcine gelatine). There is no suitable alternative flu vaccine available for otherwise healthy children. For more information on the flu vaccination programme, go to [www.govuk/government/publications/vaccines-and-porcine-gelatine](http://www.govuk/government/publications/vaccines-and-porcine-gelatine)

**YES**, I consent for my child to receive the nasal flu vaccine.

Signature of parent/guardian  
(with parental responsibility).....

Date: .....

**NO**, I do not consent for my child to receive the nasal flu vaccine.  
Please give reason why

.....

Signature of parent/guardian  
(with parental responsibility) .....

Date: .....

**NURSE USE ONLY**

Child not Immunised today due to: *(Circle as appropriate)*

Absent  
 Unanswered medical query  
 Not well on the day  
 Vaccination at GP  
 Confirmed anaphylaxia to egg  
 Immunosuppression (child)  
 Child refused (partially given)  
 DOB out of range  
 Unsigned form  
 Active Wheezing  
 Rhinitis on the day  
 Previous severe reaction  
 Salicylate (oral) therapy  
 Immunosuppression (family)  
 Child refused (none given)

**Given under:**  PGD  PSD

**Vaccine type:**  Fluenz Tetra  Injectable

If injectable given, site of injection (arm)  Left  Right

Batch Number:

Expiry Date:

Administered by:  
**Name and Signature**

Date:

**NOTES:**

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**ADMIN USE ONLY**

Consent recorded:

Vaccine recorded: