

Intra Nasal Flu Vaccination Consent Form

Please complete in BLACK INK ONLY

Child's FULL NAME (first name and surname):

Home address and postcode:



NHS number (if known):

Date of Birth:

School and year group:

Gender:

GP name, address and postcode:

Daytime contact telephone number for parent/carer:

Has your child already had a flu vaccination **since schools reopened in September 2020**? Yes No

Has your child been diagnosed with asthma? Yes No

Has your child taken steroid tablets because of their asthma in the past two weeks? Yes No

Has your child ever been admitted to intensive care because of their asthma? Yes No

Does your child have a disease or treatment that severely affects their immune system?
(e.g. treatment for leukaemia) Yes No

Is anyone in your family currently having treatment that severely affects their immune
system? (e.g. they need to be kept in isolation) Yes No

Does your child have a severe egg allergy? (requiring intensive care unit admission) Yes No

Is your child receiving salicylate therapy? (i.e. aspirin) Yes No

If you answered **Yes** to any of the above the immunisation service may contact you for further information.
Please ensure you add a contact telephone number above.

On the day of vaccination, please inform the immunisation team if your child's asthma deteriorates and you have had to increase their medication, or they have been wheezy or had a bad asthma attack in the past 3 days.

Please return this form to school as soon as possible

The nasal flu vaccine contains a highly processed form of gelatine derived from pigs (porcine gelatine). It is offered because it is more effective in the programme than an injected vaccine. This is because it is easier to administer and is considered better at reducing the spread of flu to others. More information is available from: www.nhs.uk/child-flu

**I WANT my son/daughter to receive their
Intra Nasal flu vaccine**

Name (Please print):
Parent/Guardian

Signature
Parent/Guardian

Date:



**I DO NOT WANT my son/daughter to receive
their Intra Nasal flu vaccine**

Name (Please print):
Parent/Guardian

Signature
Parent/Guardian

Date:



**For further information please contact the Immunisation Team
on 01244 397470 or email cwp.0-19immsandscreening@nhs.net**

FOR OFFICE USE ONLY

Pre session eligibility assessment for live attenuated influenza vaccine LAIV

Child eligible for Fluenz Yes No

If no give details:

Additional information:

Assessment completed by

Name, designation and signature:

Date:

Eligibility assessment on day of vaccination¹

Has the parent/child reported the child being wheezy or having a bad asthma attack over the past 3 days over the past three days? Yes No

If the child has asthma, has the parent/child reported:

• use of oral steroids in the past 14 days? Yes No

• use of oral steroids in the past 14 days? Yes No

Child eligible for Fluenz Tetra Yes No

If no give details:

Assessment completed by

Name:

Designation:

Signature:

Date:

Vaccine details

Date: Time: Batch number: Expiry date:

Signature of Nurse or Health Care Assistant administering the nasal flu vaccination

Name:

Signature:

Designation:

NB¹ Children with an acute exacerbation of symptoms including increased wheezing and/or needed additional bronchodilator treatment in the previous 72 hours should be offered inactivated vaccine to avoid a delay in vaccinating this 'at risk' group.