Triaged ◯ FAO Nurse ◯

Vaccination UK

Nasal Flu Immunisation Consent Form

NHS England

Parent / Guardian: please complete <u>ALL</u> sections on this page.

Child's full name: (first name and surname)		**Date of Birth:**
Home address: Postcode:		Emergency contact number for parent or guardian:
Email:		Gender of child *(please circle)*: **Male** **Female**
NHS Number (*if known*):		Ethnicity of child:
GP name and address:		GP telephone number:
School:		Year Group/Class:

CONSENT FOR IMMUNISATION
(Please complete ONE box only)

The person with parental responsibility must sign this form – for more information, go to:
https://www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility

I have read and understood the leaflet supplied	***I have read and understood the leaflet supplied***
YES, I want my child to receive the flu immunisation. Parent / Guardian name:…… Signature:…….. Date:……	**NO, I DO NOT** want my child to receive the flu immunisation. Parent / Guardian name:…… Signature:…….. Date:…… Reason for refusal:……

NB: The nasal flu vaccine contains products derived from porcine gelatine. There is no suitable alternative flu vaccine available for otherwise healthy children. More information for parents is available from www.nhs.uk/child-flu

Please also answer the questions below – ***if you answer YES to any questions, please give details:***		
1.	Has your child had the flu vaccine in the past **3 months**?	Yes / No
2.	Did your child receive the flu vaccine **last** winter?	Yes / No
3.	Does your child have a disease or treatment that severely affects their immune system (eg: leukaemia)	Yes / No
4.	Is anyone in your family currently having treatment that severely affects their immune system? (eg: they need to be kept in isolation)	Yes / No
5.	Does your child have a severe egg allergy (needing hospital care)?	Yes / No
6.	Is your child receiving aspirin therapy (salicylate therapy)?	Yes / No
7.	Is your child on regular steroid medication?	Yes / No
8.	Has your child had a severe (*anaphylactic*) allergic reaction to any previous vaccines given?	Yes / No
If you answered yes to any of the above please provide details here:……		

Asthmatic children ONLY:

Please enter the medication / inhaler name and daily dose (puffs):
eg: Budesonide 100 micrograms, 4 puffs per day

Is your child's asthma (please circle one): **MILD** **MODERATE** **SEVERE**

Has your child taken **steroid** tablets in the past two weeks for their asthma? **YES / NO**

If you answered **yes**, please give the date the tablets were finished? ……..

Please let the immunisation team know if your child has to increase their asthma medication after you have returned this form OR if the child has been wheezy or unwell WITH ASTHMA within 72 hours prior to the immunisation day.

FOR OFFICE USE ONLY

ELIGIBILITY ASSESSMENT **ON THE DAY OF VACCINATION:**

- **Has the child been assessed as suitable for receiving LAIV today?** **YES / NO**
- **If the child has asthma, has the parent / child reported:**
  - Use of oral steroids in the past 14 days: **YES / NO**
  - An increase in bronchodilator use since consent form completed: **YES / NO**

Asthmatic children not eligible on the day of the session due to deterioration in their asthma control should be offered IM inactivated vaccine if their condition does not improve within 72 hours to avoid a delay in vaccinating this 'at risk' group.

- If the child is not suitable to receive LAIV, has IM influenza vaccine been given today? **YES / NO**
- **If YES –** name of parent / guardian who has given consent for IM flu vaccine:

  Name:……..

  Relationship to child:……..

  Date / time contacted:……
- If the IM influenza vaccine has **not** been given today, has the child been referred back to their GP? **YES / NO**

Child not immunised today because:

High Temperature ☐

Not well enough today ☐

Refused none given ☐ Refused partially given ☐ Child Refused ☐

Nurse assessors NAME and SIGNATURE:

Live intra nasal influenza vaccine details:

IMMUNISATION	BATCH	EXP DATE	GIVEN BY: PRINT NAME	SIGNATURE / DESIGNATION	TIME / DATE
live intra nasal influenza vaccine					

If Intramuscular (IM) vaccine given today:

Manufacturer:

Batch:
Expiry:

Site given:

Given by:

- Name of nurse……..
- Signature……..

Additional notes: