Flu vaccination consent form

Thank you for completing this form. Please return it to the school as soon as possible.

Child's full name (first name and surname)	Date of birth
Home address Postcode	GP name and address
Daytime contact telephone number for parent/carer	NHS number (if known)
School	Year group/class

Medical information (Please answer all questions)

1. Has your child already had a flu vaccination this season **since 1st September**?	Yes ☐	No ☐
2. Does your child have a disease or treatment that severely affects their immune system? (e.g., treatment for leukemia, high dose steroids)	Yes ☐	No ☐
3. Is anyone in your family currently having treatment that very severely affects their immune system? (e.g., they have just had a bone marrow transplant)	Yes ☐	No ☐
4. Has your child had any of the following: • a severe allergic reaction (anaphylaxis) to eggs requiring intensive care admission. • confirmed severe allergic reaction (anaphylaxis) to a previous dose of flu vaccine • confirmed severe allergic reaction (anaphylaxis) to any component of the vaccine such as egg, neomycin gentamicin or polysorbate 80?	Yes ☐	No ☐
5. Is your child receiving salicylate therapy? (i.e., aspirin)	Yes ☐	No ☐
6. If your child has asthma: i. Is your child prescribed regular **oral** steroid tablets for asthma? ii. Has your child ever been **admitted to intensive care** because of their asthma? **If your child has become wheezy, had an asthma attack, or had to increase their use of reliever inhaler in the 3 days before vaccination is scheduled, please let the immunisation team know, either before, or on the day of vaccination.**	 Yes ☐ Yes ☐	 No ☐ No ☐
7. Are there any other medical conditions or recent/planned medical treatment that the immunisation team should be aware of?	Yes ☐	No ☐

Consent for flu vaccination (Please complete **one** box only)

☐  **YES, I want** my child to receive the **flu nasal spray** vaccination	☐  **YES, I want** my child to receive the **flu injectable** vaccination
☐  **NO, I do not want** my child to receive **any** flu vaccine	If you do not want your child to have the flu vaccine, it would be helpful to understand why:
Name Parent/Guardian	
Signature	
Date	
Any other comments	

OFFICE USE

Pre-session eligibility assessment for influenza vaccine	**Eligibility for LAIV assessment on day of vaccination[1]**
Child suitable for LAIV Yes ☐ No ☐	Heavy nasal congestion on the day of vaccination Yes ☐ No ☐
If LAIV not suitable, is child suitable for IIV Yes ☐ No ☐ N/A ☐	If the child has asthma, has the parent/child reported: • use of oral steroids in the past 14 days? Yes ☐ No ☐ • has the parent/child reported the child being wheezy, having an asthma attack or needing more reliever inhaler over the past three days? Yes ☐ No ☐
Additional information	
Assessment completed by (name, designation and signature)	Child eligible for LAIV Yes ☐ No ☐ If no, give details:
Date	
Child's ID confirmed by:	

VACCINE DETAILS

Date	Time	Type of vaccine (please circle)		Site of injection, if applicable (please circle)		Batch number	Expiry date
		LAIV	IIV	L arm	R arm		

ADMINISTERED BY

Name	Designation NURSE	Signature
Site/Clinic: SCHOOL		
Date:		