

For GP – 2nd dose For GP info only



Nasal Flu Immunisation Consent Form

Information about this vaccination will be put on your child's health records, including records at their GP surgery and those held by the NHS.

Child's Surname (BLOCK LETTERS)	Child's Forenames	Sex M / F	Ethnicity	Date of Birth
Daytime Contact Number		Address (BLOCK LETTERS) inc. postcode		
School: Year Group : R 1 2 3 4 5 Please circle		Family Doctor address & telephone number		

Since September 2018 has your child already received a flu immunisation?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Has your child ever had a nasal flu vaccination?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is your child currently receiving treatment that severely affects their immune system? <i>(for example are they receiving treatment for leukaemia)</i> see leaflet page 9	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is anyone in your household currently or recently receiving treatment that severely affects their immune system <i>(for example chemotherapy or nursed in isolation)</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is your child receiving salicylate therapy? <i>(ie: aspirin)</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does your child have long term health conditions (see leaflet page 7) including a severe allergy, Specifically an allergy to egg that has <i>resulted in anaphylaxis</i> ? Please give details:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Has your child been diagnosed with asthma?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If Yes , and your child is currently taking inhaled steroids (ie: uses a preventer or regular inhaler), please enter the medication name and daily dose <i>((eg Budesonide 100 micrograms, four puffs a day)</i>		
If Yes , and your child has taken steroid tablets because of their asthma in the past two weeks please give details:		
Please let the immunisation team know if your child has had to increase his or her asthma medication after you have returned this form. On the day of immunisation, please let the immunisation team know if your child has been wheezy in the past three days.		

PARENTAL CONSENT FOR IMMUNISATION (please complete YES or NO section)

YES, I DO CONSENT for my child to receive the flu immunisation Signature of parent/guardian Relationship to child..... Date.....	NO, I DO NOT CONSENT to my child receiving the flu immunisation Signature of parent/guardian Relationship to child..... Date.....
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For Completion by nursing staff

Uncomplicated triage eligible for nasal flu immunisation	YES <input type="checkbox"/>	NO <input type="checkbox"/>
For nurse assessment: Any pre-session nurse action	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Triaged by:	Date:	

