Shropshire Community Health NHS Trust

FLU IMMUNISATION CONSENT FORM

Parent/Guardian to complete **both** sides please.
Please return this completed form to school within **One Week.**

Children and Families Services
Phone: 01743 730028

First Name:	**Last Name:**	**Date of Birth:**
NHS No ***(if known)*:**	**GP Name and Address:**	**School Name:**
Address and Postcode:		**Year:**
Daytime phone number of parent / guardian:		**Class/Form:**

Important information about this immunisation which is given as a nasal spray

Has your child been diagnosed with asthma? **Yes** ☐ **No** ☐

If **'yes'** and your child is currently taking inhaled steroids (i.e. uses a preventer or regular inhaler), please enter the medication name and daily dose *(e.g. Budesonide 100 micrograms 4 puffs daily)*

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 to increase his or her asthma medication after you have returned the form or has been wheezy.

Has your child ever had a flu vaccination? *Date when last given*: **Yes** ☐ **No** ☐

Is your child currently having treatment that severely affects their immune system? *(For example; they are receiving treatment for leukaemia)* **Yes** ☐ **No** ☐

Is anyone in your family currently having treatment that severely affects their immune system? *(For example; they need to be kept in isolation or are receiving chemotherapy)*
If YES please answer questions on the reverse **Yes** ☐ **No** ☐

Does your child have an egg allergy? *(that's required hospital treatment)* **Yes** ☐ **No** ☐

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

If you answered '**yes**' to any of the above, please give details. Please tell us if your child has any other long term medical conditions i.e. Diabetes:

On the day of vaccination, please let the immunisation team know if your child has been unwell or required medication such as Paracetamol (Calpol®).

Information about the vaccination will be entered onto your childs health records, including records at your GP practice and those held by the NHS.

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 https://www.gov.uk/government/collections/annual-flu-programme

Consent for immunisation for my son/daughter to receive the flu nasal spray, Complete only one box below.

As the Parent/Guardian with parental responsibility **YES**, I consent for my child to receive the flu Spray **Your Relationship to the Child:** **Print Name:**	As the Parent/Guardian with parental responsibility **NO, I do not consent** to my child receiving the flu Spray **Your Relationship to Child:** **Print Name:**
Signature:	**Signature:**
Date:	**Date:**

FOR OFFICE USE ONLY

Vaccine	Route	Batch number/expiry date	Immuniser (legible signature/print)	Date Vaccine Given
Fluenz Tetra (0.2 ml)	Nasal spray			

lgd

The Fluenz nasal spray is a **live vaccine** and sometimes it is necessary for young children receiving this treatment **not** to have contact with family members immediately following vaccination. Please contact the **Immunisation Team** if you require further information.

If anyone within the family is currently having treatment that severely affects their immune system *(For example; they need to be kept in isolation or are receiving chemotherapy)* please answer the following questions. There is a theoretical potential for transmission of live attenuated influenza virus to immunocompromised contacts for one to two weeks following vaccination.

Please state the family member receiving treatment? ________________

How frequently does your child have contact? ***i.e. Daily; Weekly; Two Weekly: Rarely:*** ____________

Has the person in isolation or receiving chemotherapy received the Inactivated Influenza vaccination? ☐ **Yes** ☐ **No**

If yes please state the date they were immunised ☐

Please confirm you understand the above information ☐ **Yes** ☐ **No**

If your child has an on-going medical condition not already mentioned or communication difficulties that you would like to tell us about to assist the immunising nurses, please use the space below.

Please list any Allergies/Medical Conditions:	Medicine taken if required:
	Is this medicine in school? Please circle: YES or NO

GDPR For parents: This information will be shared by your child's Immunisation team for the following reasons:

1. Public Health England (PHE) to provide data to Commissioners for the immunisation service.
2. SSHIS: Staffordshire County Council's ICT department and Shropshire Health Informatics Service (SSHIS) work together to record and report data to GP's.

If you would like (further) details about the way we handle your child's information please ask for a copy of our Privacy Notice or access the Privacy Notice by going to
https://www.shropscommunityhealth.nhs.uk/content/doclib/10648.pdf

- For Office Use Only: Comment Sheet for Vaccinations & Immunisations

Date & Time	Comments	Signature

Entered on to RiO	Date:	Initials: