Shropshire Community Health NHS
NHS Trust

Nasal Flu vaccination consent form.

Flu can be very unpleasant for children and sometimes they end up in hospital. Vaccination helps protect your child against flu and reduces the chance of others catching flu from them. Most children are offered a nasal spray vaccine which is quick and easy to administer and is the preferred vaccine for children.

Please complete the questions below as a small number of children cannot have the nasal spray because of medical conditions or treatments. They can be offered protection through a vaccine injection instead.

The nasal spray vaccine contains a very small amount of gelatine from pigs (porcine gelatine) to keep the vaccine stable. If you do not accept medicines or vaccines that contain porcine gelatine, a flu vaccine injection is available that contains no gelatine. Please indicate on the form if you wish your child to have the alternative.

The school aged immunisation team can answer any questions you have. More information is available in leaflets found here: www.gov.uk/government/publications/flu-vaccination-leaflets-and-posters and from www.nhs.uk/child-flu

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 Email address	NHS number (if known)
School	Year group/class

Medical information (Please answer all questions)

1. Has your child received a flu vaccination in the last 4 months?	☐Yes	☐No
2. Does your child have a disease or treatment that severely affects their immune system? (e.g. treatment for leukaemia, 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. Has your child been diagnosed with asthma? 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	☐No
7. Are there any other medical conditions or recent/planned medical treatment that the immunisation team should be aware of?	☐Yes	☐No
7. If you answered Yes to any of the above questions, please give details		

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

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

OFFICE USE ONLY						
VACCINE DETAILS						
Date	Time	Nasal Spray (please circle)			Batch number	Expiry date
		Both	Left Nostril	Right Nostril		

ADMINISTERED BY	
Name	Signature
Date:	
Entered on RiO:	

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