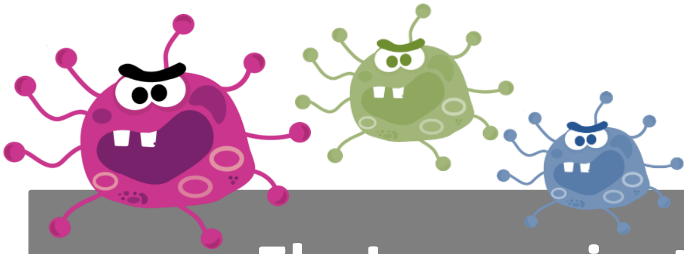


NHS
Derbyshire Community Health Services
NHS Foundation Trust

Flu Immunisation Consent Form

Important information: The nasal flu vaccine is being offered to your child and is to be given at their school. The school will advise you of the date. Please read the accompanying information leaflet and if you wish your child to receive the nasal flu vaccine, complete all sections of the form.

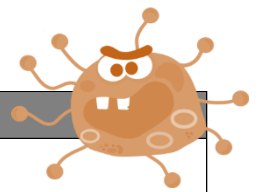
ONLY ONE CHILD PER FORM. PLEASE RETURN TO SCHOOL WITHIN ONE WEEK.

Immunisation Team Contact Details: **North** 01246 252953 **South** 01283 707178
DCHST.immunisationteam@nhs.net | www.derbyshireschoolnurses.org.uk

Patient Information	
Child's Surname:	Child's NHS Number:
Child's First Name:	Child's Gender: Male ☐ Female ☐
Child's Date of Birth:	Home Address:
Name of School:	
School Year: Class:	
GP Surgery:	
Please provide a contact telephone number for any queries relating to the consent form:	

Consent Declaration	
YES, I CONSENT for my child to receive the "Fluenz Tetra" nasal flu vaccination (if this is unsuitable for medical reasons, we will contact you to offer an alternative, injectable vaccine) • I confirm that I have parental responsibility for the above named child • I have read and understood the information given to me about the nasal flu vaccine • I understand that information provided will be shared with my GP to update my child's health records	**NO, I DO NOT CONSENT** for my child to receive the nasal flu vaccination. **Please let us know why you don't want your child to receive the nasal flu vaccine in school.** ____________________ ____________________ ____________________ ____________________
Parent/Carer's name:	Parent/Carer's name:
Relationship to child:	Relationship to child:
Signature:	Signature:
Date:	Date:

Please turn over to complete the medical information



Medical Information	Yes	No	
1. Has your child got a health condition? If your child has asthma, please let us know if their condition has worsened two weeks prior to vaccination (e.g. wheezy, changes to medication)	☐	☐	If yes, please describe
2. Does your child take any prescribed medication on a daily basis? (Including inhalers, creams etc.)	☐	☐	Please refer to the table below
3. Drug name and strength Example: Clenil Modulite Inhaler 100mg __________ __________ __________	**Dosage** 2 puffs _____ _____ _____		**How often** Twice a day __________ __________ __________
4. Does your child have any severe allergies to medication or food?	☐	☐	If yes, please describe
5. Is anyone in your family currently having treatment that severely weakens their immune system? (e.g. chemotherapy, bone marrow transplant)	☐	☐	If yes, can your child avoid close contact with them for two weeks? Yes ☐ No ☐
6. Does your child have any special needs or a disability that will require additional support during vaccination?	☐	☐	If yes, please describe

Consent form checked ☐ Initial: Date:

CLINICAL USE ONLY		
Pre-vaccination assessment completed on day by:		Nasal Flu Spray given on (date):
Child not vaccinated (please tick)		School ☐ Clinic ☐ Home ☐
Absent Asthma (severe, wheezy) Child refused Confirmed egg allergy DOB out of range Immunosuppression (child)	Immunosuppression (family) Incomplete form Not well on day Previous reaction Rhinitis on day Salicylate (oral) therapy	**Batch Number and Expiry Date:** **Assessed by:** PRINT NAME: SIGNATURE:
NOTES: Second dose recommended: ☐		**Vaccine administered by:** PRINT NAME: SIGNATURE: Inputted (date): Initials:

flu fighter®