



Student details – Parent/Guardian to complete

First Name:	Surname:	Gender:	Girl <input type="checkbox"/>	Boy <input type="checkbox"/>
Date of birth:	Home telephone:	School Name and class & year:		
NHS number (if known):	Parent/guardian mobile:			
Home address:	Email address:	GP name and address:		
Post code:				

***Please answer fully and provide additional information to any questions answered 'yes' overleaf**

Has your child received a flu vaccination since 1 st September 2018? <i>If your child receives a flu vaccination outside of school after returning this form please notify the immunisation team immediately.</i>	Yes* <input type="checkbox"/>	No <input type="checkbox"/>
Has your child ever had a flu vaccine before?	Yes* <input type="checkbox"/>	No <input type="checkbox"/>
Does your child have a disease or treatment that severely affects their immune system? <i>(e.g. chemotherapy or radiotherapy treatment for cancer or long-term steroid use)</i>	Yes* <input type="checkbox"/>	No <input type="checkbox"/>
Is anyone in your family currently having treatment that severely affects their immune system? <i>(e.g. they need to be kept in isolation)</i>	Yes* <input type="checkbox"/>	No <input type="checkbox"/>
Does your child have a severe egg allergy? <i>(that has needed hospital treatment)</i>	Yes* <input type="checkbox"/>	No <input type="checkbox"/>
Has your child ever had an allergic reaction to a vaccine or medication?	Yes* <input type="checkbox"/>	No <input type="checkbox"/>
Is your child taking aspirin or any other salicylate therapy?	Yes* <input type="checkbox"/>	No <input type="checkbox"/>
Has your child been diagnosed with Asthma? <i>If yes, do they take inhaled steroids (i.e use a preventer or regular inhaler)?</i> Please list the name/s and dose/s of all asthma medication taken:	Yes* <input type="checkbox"/>	No <input type="checkbox"/>

Does your child have any of the following conditions? Yes* No

- Respiratory Disease (other than asthma)
- Heart conditions (e.g. congenital heart disease) or liver or kidney disease
- Chronic Neurological Disease (e.g. cerebral palsy, M.E, learning difficulties).
- Diabetes or Spleen dysfunction (including coeliac syndrome, sickle cell disease)
- Cleft lip / palette awaiting repair

PLEASE REMEMBER TO LET THE IMMUNISATION TEAM KNOW IF YOUR CHILD HAS TO INCREASE THEIR ASTHMA MEDICATION AFTER YOU HAVE RETURNED THIS FORM, OR IF YOUR CHILD HAS BEEN WHEEZY IN THE THREE DAYS PRIOR TO THE BOOKED IMMUNISATION SESSION – THANK YOU

The nasal flu vaccine contains products derived from pigs (porcine gelatine). If the vaccine is refused due to this content, only children who are at high risk from flu due to a medical condition will be offered an alternative injected vaccine. More information is available from www.nhs.uk/child-flu-FAQ

A record of your child's immunisation is held on the child health information system and will be shared with their GP. It is protected by the principles of the Data Protection Act 1998

Consent for immunisation (please tick YES or NO)

YES, I consent for my child to receive the flu immunisation.	NO, I DO NOT consent to my child receiving the flu Immunisations. Please give reason (s) overleaf
Signature of parent/guardian <i>(with legal parental responsibility):</i>	Date DD/MM/YY

Additional information (to be used by parent/guardian if required)**FOR OFFICE USE ONLY****Pre session eligibility assessment for live attenuated vaccine LAIV**Child eligible for LAIV Yes No (If No, give details)

Additional Information:

Assessment completed by: Admin Team Nurse

Name & signature: Date:

Eligibility assessment on the day of vaccinationHas parent/child reported the child being wheezy over the past 3 days? Yes No

If the child has asthma, has the parent/child reported :

- Use of oral steroids in the past 14 days? Yes No
- An increase in inhaled steroids since consent form completed? Yes No

Child eligible for LAIV Yes No **Reason if not vaccinated:**

- Asthma*
- Child Refusal
- Child unwell on day of vaccination
- Contraindications
- Receiving vaccination at GP
- Other

Vaccination Details: Nasal Influenza Vaccine given under PGD

Date: Time: Batch Number: Expiry Date:

Administered by:

Name, designation & signature: