In Partnership with...

NHS
South Tyneside and Sunderland
NHS Foundation Trust

NHS
Northumbria Healthcare
NHS Foundation Trust

NASAL FLU IMMUNISATION CONSENT FORM

THIS VACCINE CONTAINS PORCINE GELATIN

Child's full name (first name and surname):	Date of Birth: _____ / _____ / _____	Gender: Male ☐ Female ☐
Home address:	Daytime telephone number for parent /carer:	
	Ethnicity:	
School:	Year group/class:	
GP name and address:	NHS number (if known):	

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS

1. Has your child been diagnosed with asthma?	YES ☐	NO ☐
2. Does your child have a severe egg allergy that has resulted in the need for hospital treatment?	YES ☐	NO ☐
3. Is your child or any of your family currently having treatment that severely affects their immune system e.g. chemotherapy, malignancy, HIV? **If yes, please give details overleaf.**	YES ☐	NO ☐
4. Is your child receiving salicylate therapy i.e. Aspirin?	YES ☐	NO ☐
5. **Do you agree to inform the immunisation team if your child receives the flu immunisation elsewhere (e.g. at your GP) this year, from September 2021?**	YES ☐	NO ☐

CONSENT FOR THE NASAL FLU IMMUNISATION, PLEASE COMPLETE ONE BOX BELOW

CONSENT

Yes - I would like my child to receive the nasal flu vaccination

Parent/Carer Name:

Relationship to child:

Signature:
(Parent/Legal Guardian)

Date: _____ / _____ / _____

NON CONSENT

No - I do not want my child to have the nasal flu vaccination

Parent/Carer Name:

Relationship to child:

Signature:
(Parent/Legal Guardian)

Date: _____ / _____ / _____

Prior to the day of immunisation please let the team know if your child has been wheezy or has needed an increase in their asthma medication in the previous three days

OFFICE USE ONLY			
Date of nasal flu vaccination: _____ / _____ / _____	Batch number/ expiry date	Immuniser (please print)	Where administered (school, college, GP etc)

DETAILS OF TREATMENT CURRENTLY BEING GIVEN TO CHILD OR FAMILY MEMBER - TO BE COMPLETED BY PARENT / GUARDIAN

OFFICE USE ONLY		
Eligibility checked by:	Signed:	Date: _____ / _____ / _____
Date of attempted vaccination: _____ / _____ / _____	Reason vaccination not given:	
Date: _____ / _____ / _____	Post immunisation issues / adverse reactions / notes:	