INFLUENZA VACCINATION CONSENT FORM 2018 / 2019

Sussex Community NHS
NHS Foundation Trust

The Q&A sheet that accompanies this form tells you about the Influenza vaccination and why it is being offered. If you have more questions, please contact the Immunisation team on 01273 696011 ext. 3789 / 8100 or 01293 600300 ext. 3985 or visit the NHS Choices website www.nhs.uk (search for flu vaccine) or alternatively send an email with your questions to sc-tr.fluvacc@nhs.net

Child's full legal name *(first name and surname)* ***and*** *name known as if different:*		**Date of Birth:** **Male ☐ Female ☐**
Home address:	Daytime **contact telephone number** / mobile for Parent(s) / Guardian(s) *We may use this number to contact you regarding vaccination.*	
Postcode:	NHS Number *(if known):*	Ethnicity:
School:		**Year group:**
GP Surgery name and address:		**Class name:**

Please tick either YES or NO for all of the following questions.	**YES**	**NO**
Does the above named child have any severe allergies to egg, gentamicin or previous flu vaccination?		
Is the above named child immunocompromised? *E.g. undergoing treatment for Leukaemia or in isolation*		
Are any household members having treatment that severely affects their immune system requiring isolation? E.g. *chemotherapy, bone marrow transplant. If so, avoid close contact with them for 2 weeks*		
Is the above named child taking any medication? **If yes, give details of medication and doses overleaf** (E.g. Inhalers, immunosuppressants etc.)		
Does the above named child suffer with a respiratory / heart / kidney / liver / neurological condition or have diabetes, coeliac disease, sickle cell or splenic dysfunction?		

Consent for Influenza vaccination programme **(Please complete one box only)**

YES, I CONSENT

for the above named child to receive the Influenza vaccine.

By signing this form I confirm the following statements:

I confirm I have parental responsibility for the above named child

I have read and understood the information given to me about the Influenza nasal vaccine.

I understand that this information will be held in the above named child's health record and also shared with their GP.

Full Name of Person with Parental Responsibility:

Signature of Person with Parental Responsibility:

Date:

NO, I DO NOT CONSENT

for the above named child to have the Influenza vaccine.

Please tick reason for declining below and return form to the school.

☐ My child has had (in the past four months) or will be having the vaccine at our GP surgery.
☐ Do not feel that the vaccine is necessary.
☐ Due to a previous allergic reaction to the vaccine.
☐ Due to the contents of the vaccine.
☐ Other *(please state)* use separate sheet if necessary
……

Full Name of Person with Parental Responsibility:

Signature of Person with Parental Responsibility:

Date:

Office Use – Initial appropriate box(es) No action …… Demographic query …… Clinical query …… Query completed ……

Thank you for completing this form. Please detach and return to the school within one week of receipt

Academic Year 2018/19

Medication – extra information	Dose	Times

FOR OFFICE USE ONLY

Vaccination Not Received – Date & Initial Reason

Unwell ☐	Refused ☐	Withdrawn Consent ☐	Absent ☐	Other ☐ Detail on Communication Sheet
Date:	Date:	Date:	Date:	
Initial:	Initial:	Initial:	Initial:	

Eligibility assessment on day of vaccination *(Please tick as appropriate)*	YES	NO
Has the parent/child reported the child being wheezy over the past three days?		
If the child has asthma, has the parent/child reported any reason why vaccination should be postponed? e.g: *Use of oral steroids or, an increase in inhaled steroids in the past 14 days?*		
Is the child unwell (with fever) today or has an audible wheeze?		
Does the child have any contraindications today for the Nasal Influenza Vaccination		
Letter received from parent		

Date of vaccination	Batch No & expiry date	Nurse checking & supplying vaccine (print & sign)	Administered by (Initial)

Information given as per PGD ***(Please tick)*** ☐	Where administered? (if not school)	*School*

NAME:		*Child demographics to be completed if scanning or photocoping this form.*	
DOB:		NHS No:	

IMMUNISATION COMMUNICATION RECORD

Date/Time		Name, Title & Signature