**Child’s name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Medical Information**: Please complete this section fully as any gaps may lead to the vaccine not being given. |
|  | **Yes** | **No** | **If yes, please give details** |
| Has your child had the **nasal** flu vaccine before? |  |  |  |
| Has your child had a bad reaction to any previous flu vaccine or to a medicine called gentamicin?  |  |  |  |
| Does your child have an egg allergy, which has been confirmed by a specialist doctor or at an allergy clinic?  |  |  |  |
| Has your child got a health condition or are they receiving treatment that severely weakens their immune system?  |  |  |  |
| Is anyone in your family currently having treatment that severely weakens their immune system (e.g. bone marrow transplant recipient requiring isolation)?  |  |  |  |
| If yes to the above question, can your child avoid close contact with them for two weeks after receiving the vaccine?  |  |  |  |
| If your child receiving oral salicylate therapy (i.e. aspirin)? |  |  |  |
| Does your child have asthma?  |  |  |  |
| If yes to the above question, please list the medication they take: **Drug name and strength Dosage How Often***Example Clenil Modulite Inhaler 100mg 2 puffs Twice a day*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Any unusual symptoms following the flu vaccination should be reported to the nurse or GP

Any unusual symptoms following the flu vaccination should be reported to the nurse or GP

**Consent**

I consent for my child to receive the influenza vaccination

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to child**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_