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