INFLUENZA VACCINATION CONSENT FORM 2020 / 2021 PLEASE COMPLETE USING BLOCK CAPITALS IN BLACK INK



Before completing, please read the FAQ's attached to this form. Please ensure ALL boxes marked (*) below are complete.

Any missing information may result in your child not being vaccinated on the day of the school session.

Legal Forename:	Date of Birth:*			Male 🗆					
		DD	MM	YYYY	Fema	le 🗆			
Name known as, if different: Eth					nicity:				
Contact Telephone Number & Email Address for Parent or Guardian*Home Address: *We may use to call, text or email regarding this vaccination									
	Postcode:*								
Email:									
GP Surgery Name & Town:* NHS Number (if known)									
Year Group:*				Class Name:					
Please complete ALL questions below by ticking either YES or 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 Leukemia or in isolation.*									
Are any household members in isolation due to being immunocompromised? E.g. chemotherapy, bone marrow transplant. If so, avoid close contact with them for 2 weeks.									
I consent to the above named child's Digital Health (e.g. GP) Record being available to be viewed by SCFT staff involved in their care									
List ALL medication or inhalers taken by your child below.									
	accination	Accination Postcode:* Year Group:* Stions below by ticking either YE ergies to egg, gentamicin or previous flu v E.g. undergoing treatment for Leukemia of being immunocompromised? E.g. chemother for 2 weeks. h (e.g. GP) Record being available to be very set of the se	Ethnici or Parent or Accination Postcode:* Year Group:* Stions below by ticking either YES or N ergies to egg, gentamicin or previous flu vaccinatio E.g. undergoing treatment for Leukemia or in isola eing immunocompromised? E.g. chemotherapy, bo for 2 weeks. h (e.g. GP) Record being available to be viewed b	Ethnicity: or Parent or Accination Postcode:* NHS N (if known Year Group:* Class Stions below by ticking either YES or NO ergies to egg, gentamicin or previous flu vaccination?* E.g. undergoing treatment for Leukemia or in isolation.* eing immunocompromised? E.g. chemotherapy, bone marr for 2 weeks. h (e.g. GP) Record being available to be viewed by SCFT set	Image: constraint or previous flu vaccination Year Group:* Class Name: Stions below by ticking either YES or NO ergies to egg, gentamicin or previous flu vaccination?* E.g. undergoing treatment for Leukemia or in isolation.* eing immunocompromised? E.g. chemotherapy, bone marrow for 2 weeks.	Image: Second secon			

Medication	Dose	Additional Information

Consent for Influenza Vaccination Programme (please complete one box only) *

YES, I CONSENT	NO, I DO NOT CONSENT					
for the above named child to receive the Influenza vaccine.	for the above named child to have the Influenza vaccine.					
By signing this form I confirm the following statements: I have parental responsibility for the above named child. I have read and understood the information about the Influenza nasal vaccine. I understand that this information will be held in the above named child's health record and shared with their GP.	 Please tick reason for declining below and return form to the school. My child has had the vaccine in the past four months. 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	Full Name of Person with Parental Responsibility:					
Signature of Person with Parental Responsibility:	Signature of Person with Parental Responsibility:					
Date:	Date:					
Office Lise – Initial appropriate box(es) No action Demog	raphic query Clinical query Ouery Completed					

FOR OFFICE USE ONLY													
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 fro	om parent	t?											
ONLY If the child	l is unabl	le to c	onfir	m 2 unique	identifiers, r	ecord th	he d	etails of	whom the	Identif	fy was con	firmed by:	
Name:			Job F	Role:		Date & Time:					Nurse Initi	Nurse Initials:	
Date of Vaccination Batch No & Date				piry Nurse Checking Supplying Vacc (print & sign)						Where Administered (if not school)			
Information given as per PGD (please tick)													
Vaccination Not Received – Date & Initial Reason													
Unwell 🗆	Refu	used 🗆	U Withdrawn Consent			Absent Other					Returned for Vaccination		
Date:	Date:		Date:			Date:			Detail on		Date:		
Time:	Time:			Time:		Time: communica sheet.				tion Time:			
Initial:	Initial:	Initial:				Initial:					Initial:		
				СОМ	MUNICATI	ON R	REC	ORD					
NAME:											raphics to be nting below th		
DOB:						NHS	S N	o :					
Date & Time:			Pho	one call to p	arent – Messa	ge left to	o ca	ll the tear	m back 🗌	In	itial:		
Date/Time												e, Title & nature	
											_		