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| **Child Information and Contact Details** |
| Surname: | First Name: |
| Date of Birth: | Age: | NHS Number (*if known*): |
| Gender: Male 🞎 Female 🞎  | GP Surgery Name: |
| Home Address:Post Code: | GP Telephone: |
| GP Address:Post Code: |
| School Name: |
| School Year: | Class: |
| **We may need to contact you to discuss any queries. Please provide your contact details** |
| Day time contact number: | Mobile number: |
| Email Address: |
| May we contact you for feedback on our service? Yes/No (delete as appropriate)If yes, please tell us how we can contact you. Post 🞎 Email 🞎 |
| **Consent Declaration \*\*\*MUST BE SIGNED\*\*\*** **and returned as soon as possible.** |
| **🞎 Yes, I consent for my child to receive the nasal flu vaccine,** | **🞎 No, I do not consent for my child to receive the nasal flu vaccine****\*\*\*You are NOT required to complete medical questionnaire \*\*\*** |
| **SIGNATURE OF PARENT/CARER - (with parental responsibility)** **Print Name: Date:**  |
| **Medical Questions - please complete in full if consenting yes** | **No** | **Yes** | **If Yes, provide details** |
| Does your child have any severe allergies to food such as egg or any medicines including vaccines? (E.g. previous LIFE THREATENING allergic reaction) |  |  |  |
| Has your child had their flu vaccine within the last four months? (E.g. at your GP surgery) |  |  |  |
| Is your child receiving salicylate therapy (blood thinning medication)?(i.e. aspirin) |  |  |  |
| Is your child currently having treatment that severely affects their immune system? (For example they are receiving treatment for leukaemia) |  |  |  |
| Is anyone in your family currently having treatment that severely affects their immune system?(for example they need to be kept in isolation) |  |  |  |
| Does your child have asthma?If Yes, and your child is currently taking oral or inhaled steroids (e.g. tablets or uses a preventer or regular inhaler), please enter the medication name and daily dose (e.g. Budesonide100 micrograms, four puffs per day) |  |  |  |
| Please let us know if your child has any medication changes after you return this form. |
| **What else would you like to tell us?** |
|  |
| **Thank you for completing this form please return to school as soon as possible** |
| If you would like to speak to one of our nurses please call 0300 123 5205 or email kchft.cyp-immunisationteam@nhs.net  |
| **For Immunisation team staff use only** |
| **Vaccinator must tick**  | **Yes** | **No** | **Vaccinator must tick**  | **Yes** | **No** |
| Details correct on consent form? |  |  | Any known allergies? |  |  |
| Confirm correct cohort for vaccination? |  |  | Patient information leaflet given? |  |  |
| Child well today? |  |  |  |  |  |
| **Vaccination Administration details**  |
| Vaccine name | Batch number & expiry date  | Intranasal Please tick | Date & time given | PGD | PSD | Name and Signature and designation of healthcare professional |
| L | R |
| Fluenz Tetra |  |  |  |  |  |  |  |
|  |  |
| **Healthcare Professional comments/actions/ additional notes**  |
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