Shropshire Community Health NHS Trust

School Aged Immunisation Service (SAIS)

Phone: 01743 730028

LIVE NASAL INFLUENZA CONSENT FORM 2024/25

Parent/Guardian to complete **both** sides please.

Please return this completed form to school within **One Week.**

First Name:	**Last Name:**	**Date of Birth:**
NHS No *(if known):*	**GP Name and Address:**	**School Name:** **Year:** **Class/Form:**
Address and Postcode:		
Daytime phone number of parent / guardian:		

Has your child been diagnosed with asthma? **Yes** ☐ **No** ☐ If **'yes'** and your child is currently taking inhaled steroids (i.e. uses a preventer or regular inhaler), please enter the medication name and daily dose *(e.g. Budesonide 100 micrograms 4 puffs daily)* Does your child have severe asthma that has required ITU admission or regular oral steroids, if so, has their consultant agreed to them receiving this vaccine, please give details: **Please let the immunisation team know if your child has had to increase his or her asthma medication after you have returned the form or has been wheezy.**	Has your child had a flu vaccination **this flu season (since September 2024)?** **Yes** ☐ **No** ☐ Is your child currently having treatment that severely affects their immune system. *(For example; they are receiving treatment for leukaemia)* **Yes** ☐ **No** ☐ Is anyone in your household currently having treatment that severely affects their immune system? *(For example; they need to be kept in isolation or are receiving chemotherapy)* **Yes** ☐ **No** ☐ ***If YES please answer questions on the reverse*** Does your child have a **severe** egg allergy *(that's required ITU treatment)* **Yes** ☐ **No** ☐ Is your child receiving salicylate therapy (*i.e. aspirin)* **Yes** ☐ **No** ☐ **If your child has any allergies, please give details:** **If your child takes any medication, please give details:** If you answered '**yes**' to any of the above, please give details. Please tell us if your child has any other long-term medical conditions eg. Diabetes: **On the day of vaccination, please let the immunisation team know if your child has been unwell or required medication such as Paracetamol (Calpol®).**

Consent for immunisation for my son/daughter to receive the flu nasal spray, Complete only one box below.

As the Parent/Guardian with legal delegated authority **YES**, I consent for my child to receive the flu Spray **Your Relationship to the Child:** **Print Name:**	As the Parent/Guardian with legal delegated authority **NO, I do not consent** to my child receiving the flu Spray **Your Relationship to Child:** **Print Name:**
Signature:	**Signature:**
Date:	**Date:**

The Fluenz nasal spray is a **live vaccine** and sometimes it is necessary for young children receiving this treatment **not** to have contact with family members immediately following vaccination. Please contact the **Immunisation Team** if you require further information.

NB. The nasal flu vaccine contains porcine gelatine (derived from pigs). Nasal Flu remains the most effective vaccine for this age group, however an alternative is available: Please contact The Immunisation Team on 01743 730028.

Please do not complete this form for the alternative vaccine.

If anyone within your household is currently having treatment that severely affects their immune system *(For example; they need to be kept in isolation or are receiving chemotherapy)* please answer the following questions. There is a theoretical potential for transmission of live attenuated influenza virus to immunocompromised contacts for one to two weeks following vaccination.

Please state which household member is immunocompromised: _____

Has the immunocompromised person received the Inactivated Influenza vaccination? Yes ☐ **No** ☐

If yes please state the date they received their Inactivated Flu vaccination:

Please confirm you understand the above information Yes ☐ **No** ☐

If your child has an on-going medical condition not already mentioned or communication difficulties that you would like to tell us about to assist the immunising nurses, please contact the team.

GDPR For parents: This information will be shared by your child's Immunisation team for the following reasons:

1. Public Health England (PHE) to provide data to Commissioners for the immunisation service.
2. SSHIS: Staffordshire County Council's ICT department and Shropshire Health Informatics Service (SSHIS) work together to record and report data to GP's.

If you would like (further) details about the way we handle your child's information please ask for a copy of our Privacy Notice or access the Privacy Notice by going to **https://www.shropscommunityhealth.nhs.uk/content/doclib/10648.pdf**

- **For Office Use Only: School Aged Immunisation Service.**

Registered Nurse Assessment: **Child suitable for immunisation:** ☐ **Yes** ☐ **No** **Signature:** **Print Name:** **Date:**	**Child not immunised today because:** **Not well enough today:** **Refused (not given)**

Vaccine	**Batch number/expiry**	**Immuniser signature**	**Immuniser print Name**	**Date Given**
Fluenz Tetra (0.2 ml) **Nasal spray**				
Entered on to RiO	Date:	**Print Name**	Initials:	